HEALTH REFORM IN THE DISTRICT OF COLUMBIA

Sale of Group Health Association, Inc. to Humana, Inc.

HEARING

BEFORE THE

COMMITTEE ON THE DISTRICT OF COLUMBIA HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

ON

THE PROPOSED SALE OF GROUP HEALTH ASSOCIATION (GHA) TO HUMANA, INC.

SEPTEMBER 14, 1993

Serial No. 103-7

Printed for the use of the Committee on the District of Columbia

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CONTENTS

STAFF SUMMARY OF FINDINGS AND CONCLUSIONS

On Tuesday, September 14, 1993, the Committee on the District of Columbia continued its hearings on health reform in the District of Columbia, focusing on the proposed sale of Group Health Association, Inc. (GHA) to Humana, Inc. Prior to the proposed sale GHA, with 132,000 members in the Washington, D.C. metropolitan area, had operated as a nonprofit, staff model health maintenance organization (HMO) with a consumer board. Humana is a for-profit corporation.

Chairman Pete Stark noted in opening the hearing that the role of HMOs as providers of health care would likely become preeminent under reform legislation proposed by the administration. In anticipation of that, smaller HMOs are being merged or bought outright by larger ones. Thus, the GHA-Humana transaction has implications for national policy-making.

At the hearing, the Committee received testimony on national trends in the HMO industry; problems with access to care for HMO enrollees; particularly for low-income and underserved populations; tax implications of the conversion of a nonprofit HMO to for-profit status; the reasons for the GHA-Humana transaction; and concerns of area regulators. Witnesses included government officials, health care experts familiar with HMO operations, and individuals familiar with the proposed sale of GHA to Humana.

Trends in the HMO Industry

In the course of the hearing, the Committee was told that 16 percent of the United States population is served by the $45.6 billion HMO industry, including over 1.6 million Medicare beneficiaries and 3.6 million Medicaid enrollees. Ten HMOs, seven of which are for-profit, enroll 53 percent of all HMO enrollees nationwide. Over 60 percent of individuals covered by HMOs belong to plans with more than 100,000 people enrolled.

The total number of HMOs in the United States reached a high of 647 in 1987. There has been a consolidation since that time, as a result of failures, mergers, and acquisitions. Between 1980 and 1990, there were 178 HMO failures, 148 mergers, and 147 acquisitions. The Humana purchase of GHA exemplifies this trend.

The GHA-Humana transaction is also reflective of the marked decline in the number of HMOs that are nonprofit entities. From 1985 to 1990, the number of nonprofit HMOs declined from 256 to 188, while HMOs organized for profit increased from 137 to 368.

Another trend has been an increase in independent practice association (IPA) and network-type HMOs as compared to staff and group models. Of the 553 HMOs operating at the end of 1991, 346 (63 percent) were IPAs, which rely heavily on solo-practice physicians. Of the total number of HMOs in 1991, 168 (or 30 percent)

were group-type models. This is a reversal of the 70 percent to 30 percent ratio of group to IPA models that existed in 1974.

Over the past decade, commercial health insurers have established a significant presence in the HMO market. In 1982, commercial insurers received 0.3 percent of their profits from HMOs. This had increased to 25.3 percent by 1990. Commercial insurers own 43 percent of HMOs nationwide and cover more than 27 percent of HMO enrollees.

HMOs are concentrated in densely populated regions in which marketing is focused on suburban and affluent areas. Fifty-six percent of HMOs operate in the 30 largest metropolitan areas.

These trends, together with other industry changes in ownership and control, horizontal and vertical integration, diversification, and consolidation, have converged in what one witness termed the "corporatization of health care." Providers respond to pressure to set up "profit centers." Patients who are not profitable are avoided.

This has been accompanied by a growth of "administrative medicine," exemplified by the creation of the American College of Physician Executives. The Committee was told during the hearing that this physicians' "specialty," which is largely an unregulated group of medical professionals, is concerned primarily with achieving positive "bottom line results." Physicians who are providing services to patients as part of a plan are subject to "economic credentialing," whereby they are evaluated according to their economic efficiency.

Ways HMOs May Limit Access to Quality Health Care

The trends described above are not limited to for-profit enterprises, but extend as well to nonprofit providers. While a majority of patients report receiving satisfactory care at HMOs, a number of concerns were raised by witnesses. The concerns primarily involved limitations on access to what was perceived to be necessary care.

A number of ways in which HMOs may limit access to health care were described to the Committee. Examples are as follows:

- The description of the HMO benefit package may be misleading. For example, "long term care" might be redefined to mean only 90 days.
- A general practitioner may be used as a gatekeeper to approve procedures and use of specialists.
- Use of durable equipment such as wheelchairs or walkers may be restricted in some instances, but not in others.
- Patients may be denied the freedom to choose their own physicians, thus driving users of services out of HMOs to fee-for-service plans.
- Facilities may be located in areas not easily accessible to certain underserved populations.
- Marketing may be such that only selected segments of the population are targeted.
- Physicians and providers may be given financial incentives to restrict or withhold care, or threatened if their treatment is too costly.
- Inadequate explanatory information may be given regarding benefits, coverage, and available providers prior to enrollment.

- Technical and procedural designs may be built in that make obtaining treatment or benefits difficult for patients.
- Medical reviewers may be given overly broad discretion to deny benefits, including making decisions regarding whether procedures or supplies are "medically necessary."
- Reviewers may be given targets or quotas for denial rates or monetary incentives tied to their ability to control costs.
- A plan may be more restrictive in approving procedures if they are not performed at facilities offering a discount, or at the plan's own facilities.
- Grievance and appeal procedures may be poorly designed or provide time limits too short in order for patients to file a grievance.
- Decisions on treatment may be delayed, resulting in patients lapsing into conditions that will no longer be responsive to treatment.

Tax Implications of Converting an HMO from Nonprofit to For-Profit Status

The income of an HMO may be exempt from taxation under one of two sections of the Internal Revenue Code. Section 501(c)(3) concerns charities, while section 501(c)(4) deals with social welfare organizations. The Committee was told that one-third of the Nation's HMOs are exempt from Federal income taxes, usually pursuant to section 501(c)(4).

State laws typically have restrictions on how the assets of a nonprofit organization can be used upon the dissolution of the organization. When an entity is organized for charitable purposes, its charter, bylaws or other governing instrument must normally provide for the disposition of the assets of the organization upon liquidation in a manner that is consistent with its charitable purpose. Thus, the assets must either be transferred to another nonprofit, or to the government, for a public purpose.

A Treasury Department witness told the Committee that the Department has no regulations, revenue rulings or case law expressly dealing with the purchase of a tax-exempt HMO by a for-profit corporation. As a result, the tax consequences of such a transaction are not entirely clear. Because no part of the earnings of a charitable organization may inure to the benefit of a private individual, Treasury would likely look closely at the value ascribed to the acquired entity. Sale of a nonprofit at a bargain price may indicate private inurement.

The GHA-Humana Transaction

GHA is the oldest HMO in the Washington, D.C. area, having been founded in 1937. One ramification of this is that its enrollees are older (and sicker) than the population in general. A relatively high percentage of members are over the age of 45. Its premiums are among the highest in the area.

The reason cited by GHA for its decision to seek to be acquired was that GHA faced significant difficulties, including a weak income statement, a weak balance sheet, and an inability to attract sufficient financial resources to meet capital needs. Problems were

exacerbated by several years of labor friction, including two work stoppages by its unionized medical staff. Faced with increased competition in the HMO market, GHA margins were well below the 4 to 6 percent level of industry competitors. After experiencing a peak in membership in 1991 of 156,000, enrollment slipped back to the historic average of 132,000 members in 1993. With enrollment flat and HMO competitors expanding, GHA's share of the area HMO market dropped to 8 percent, down from 41 percent in 1984.

In 1991, GHA eliminated 100 positions and cut administrative expenses $1.7 million. Two hundred more positions and $1.4 million in administrative expenses were cut in 1992. Despite these adjustments in operations, the GHA management proposed to its Board of Directors that GHA consider exploring a merger or acquisition. GHA management held discussions with 13 organizations, both for-profit and nonprofit. The Board of Directors recommended the sale of GHA's assets and liabilities to Humana. While an earlier attempt to convert GHA to a for-profit entity were rejected by members, in August of 1993, 91 percent of the 37,000 GHA members who voted approved the proposed sale.

Humana operates health care plans covering 1.7 million members, including 262,300 Medicare beneficiaries and 128,000 Federal employees. In order to make GHA a viable competitor, Humana officials told the Committee that Humana plans to infuse additional capital into GHA, introduce new insurance products, expand physician and hospital networks, improve facilities, and add new ones. Humana has also said it will strive to maintain established physician-patient relationships and member involvement. An important consideration for the GHA board were representations by Humana that members, especially individuals and small groups, would be protected.

The GHA Articles of Incorporation provide that assets on dissolution must go to a nonprofit entity. A group of GHA trustees has begun working to set up such a successor nonprofit. Proceeds of the sale (estimated to be in the range of 10 to 12 million dollars) will be used to establish a foundation organized for scientific, educational, or charitable purposes related to health care.

Not all those involved with GHA believe that the sale is necessary, or that members' interests will be adequately protected. While the organization has had problems, opponents of the sale point out that it is close to being in the black and expressed the view that a short-term crisis had caused unnecessary panic. With proper leadership, they believe that GHA could improve its competitive position.

Chairman Stark noted during the hearing Humana's record of high disenrollment when it has come into a community, effectively eliminating certain user groups. Serious concern was expressed by one witness at the hearing regarding three particularly vulnerable categories of GHA members: direct pay members in their 40's and 50's; those with chronic, pre-existing conditions; 200 small employer groups. Representatives of Humana testified, however, that Humana has made a lifetime commitment to current GHA members.

At the time of the hearing, details of the sale were still being negotiated. Physicians have established their own professional corpo-

ration, with encouragement from GHA. Organized by Doctors Donald Mitchell and Charles Trotman, the physicians would deal with the Humana-owned GHA on a capitated basis. There would be some risk sharing, but the downside risk for physicians was described as minimal. A potential cause for delay is a suit filed in D.C. Superior Court challenging the validity of the member referendum approving the proposed sale.

One open question that remains of concern to the Committee is the way in which the revamped GHA program will be marketed by Humana. Compensation of sales agents solely on a commission basis could contribute to misleading marketing practices, as has occurred in other jurisdictions. In response to an inquiry from the Chairman as to the manner in which sales representatives would be compensated, Humana commented:

> "Before Humana decides how to compensate the Medicare sales agents, we will survey the market practices of competitors to establish how others compensate salespersons. Based on those results, a decision on how to compensate salespeople will be made. In order to avoid any possibility of unethical sales practices by Humana Medicare sales agents, Humana has implemented sales policies in each of its markets which provide for thorough and ongoing training and monitoring of sales agents.' "

Questions were raised as to the availability of GHA facilities to Medicaid recipients. Other HMO insurers, such as Prudential, have decided not to enroll Medicaid eligibles because D.C. law requires that all providers in a plan must be available to all patients in the plan, assuming sufficient capacity. Humana does accept Medicaid patients in other jurisdictions. While it was reported that GHA could accommodate 20,000 to 25,000 new enrollees with existing resources, Humana representatives could did not speak to its likely practice in the District once the sale is consummated. They were also unable to address what might be done to place facilities in areas now underserved by health care providers. Only one HMO currently serves Medicaid enrollees in the District.

Regulatory Concerns

The Health Care Financing Administration (HCFA) has oversight responsibility for Medicare managed care programs. There are 420 HMOs that are "federally qualified" to provide treatment to Medicare patients. Of these, 190 are approved as direct Medicare contractors. The direct contractors receive ongoing monitoring. GHA was granted Federal qualification in 1977. It entered into an agreement with HCFA as a Medicare contractor in 1983. GHA was investigated by HCFA in 1991 because of fiscal concerns. A corrective action plan initiated by GHA resolved the agency's concerns.

HCFA has published in draft form regulations on risk sharing agreements between HMOs and physicians. The proposed regulations, which have been praised by some as tough and forward looking, have been delayed in part because of objections raised by some in the HMO industry. HCFA does have guidelines in place regarding disenrollment from Medicare and is in the process of gathering information on why there is a seemingly high rate of disenroll-

ment. In an acquisition or merger like the proposed GHA-Humana transaction, HCFA will conduct a review if the successor organization seeks Federal qualification. The review includes the adequacy of the delivery network, fiscal soundness, and the existence of a suitable beneficiary appeals process.

A 1939 court ruling in the District of Columbia held that GHA was not an insurance company for purposes of regulation. No statute regulating HMOs had been enacted as of the date of the hearing, although a bill pending before the City Council would follow recommendations of model legislation recommended by the National Association of Insurance Commissioners. The proposed statute focuses on financial condition, rate stability, quality of coverages, impact on provider networks, and ability to meet transaction obligations. GHA, Humana and District Officials are negotiating a consent order providing appropriate regulatory leverage to review this transaction.

PROPOSED SALE OF GROUP HEALTH ASSOCIATION, INC. (GHA) TO HUMANA, INC.

TUESDAY, SEPTEMBER, 14, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE DISTRICT OF COLUMBIA,
Washington, DC.

The committee met, pursuant to notice, at 10:13 a.m. in room 1310–A, Longworth House Office Building, Hon. Pete Stark (chairman of the committee) presiding.

Members present: Representatives Stark, Norton and Ballenger.

Majority staff present: Broderick D. Johnson, staff director; Louise Winston, research assistant; Marvin R. Eason, Rene Carter, and Ashley Rehr, staff assistants; and Doneg McDonough of the Committee on the District of Columbia.

Minority staff present: Dennis G. Smith, staff director; Ellen Brown, Nancy Noe, and Richard T. Dykema, staff assistants.

OPENING STATEMENT OF CHAIRMAN PETE STARK

The CHAIRMAN. Good morning. I apologize for the late start.

This morning the Committee on the District of Columbia will focus on issues relating to the proposed sale of Group Health Association, Inc. (GHA) to Humana, Inc. GHA is a Washington institution, operating as a staff model HMO with a consumer board and consumer management in the form of a cooperative. It has 130,000 members in the Metropolitan Washington Area.

Under the administration's current proposal for health reform, the role of HMOs as providers will likely become preeminent. In anticipation of those reforms, we see in the marketplace sort of a Pacman behavior, with smaller HMOs being gobbled up by the larger ones. In the proposed GHA/Humana sale the need for capital in order to expand and the stated inability to generate it internally has been cited as a primary reason for the sale of GHA, a nonprofit entity, to Humana, a for-profit entity.

Of particular concern are tax implications of HMO conversions. When assets have been built up over a period of years, while enjoying a tax-exempt status, our tax rules require that the value of the HMO, both tangible and intangible, be preserved in some nonprofit entity. In addition, the conversion should not provide an opportunity for officers of nonprofit HMOs to enrich themselves by the transaction.

We will hear testimony concerning HMO industry trends in order to consider how effective HMOs have been in containing growth in expenditures and providing quality care. We will get

some comments on cost containment and how it varies by HMO type, whether an IPA, network, or a staff group model. We would like to cover issues of the need for capital and the ability to raise capital among for-profit and nonprofit providers.

Humana has stated the intention to provide a capital infusion of $40 million. As a for-profit business, it clearly expects a return to its investors on that investment, and it will be interesting to know what changes would be made to achieve a profit in this market and, perhaps, in the prospective market after health reform.

If HMOs are going to be relied on to provide higher quality care at less cost for Medicaid patients and other poor and uninsured or marginally employed workers, it would be interesting to know which types of HMOs have had experience in providing quality care to underserved or underprivileged populations, and also those which have a record of cost containment.

Finally, we hope witnesses will discuss how the proposed sale affects the availability of coverage, access to services, quality of care for current GHA members in this region; in particular, what commitments are being made to the 8,900 nongroup GHA members who would be most vulnerable, what has been the experience of the acquiring corporation, when it purchased plans in other areas. Federal and local regulators with the authority to review and approve transactions such as this one will discuss the adequacy of their regulatory authority to see that quality care is provided.

The proposed sale of GHA to Humana represents a very timely opportunity to review one transaction in light of nationwide trends. It is important to note that the President assumes in his plan that there will be an alliance in every State, and without intruding on my colleagues' disposition to create a State or not, we are in the position, relative to these alliances here in the District of Columbia, of having to form an alliance, and we will not be in a position to trade back and forth with the surrounding States. So this could be the first look at how the President's new proposal might work in this enclave of 600,000 people.

I would be happy to recognize Mr. Ballenger for any comments he would like to make.

[The prepared opening statement of Chairman Stark follows:]

OPENING STATEMENT

THE HONORABLE PETE STARK
CHAIRMAN
COMMITTEE ON THE DISTRICT OF COLUMBIA

SEPTEMBER 14, 1993

This morning the Committee on the District of Columbia will focus on issues relating to the proposed sale of Group Health Association Inc. (GHA) to Humana Inc. GHA is a Washington institution -- operating uniquely as a staff model HMO with a consumer board. With over 132,000 GHA members in the Metropolitan Washington area, the proposed sale could have a substantial effect on health care access and affordability in this region.

Under the administration's proposal for health care reform, the role of HMOs as providers of health care would likely become preeminent. In anticipation of the proposed reforms, we see in the marketplace a "PAC man" behavior with smaller HMOs being merged or bought outright by larger HMOs in an effort to enhance market positions. In the proposed GHA-Humana sale, the need for capital in order to expand (and the stated inability to generate it internally) has been cited as a primary reason for the sale of GHA, a nonprofit entity, to Humana, a for-profit entity.

Of particular concern are the tax implications of HMO conversions. When assets have been built up over a period of years while enjoying tax exempt status, our tax rules require that the value of the HMO -- both tangible and intangible assets -- be preserved in some nonprofit entity. In addition, the conversion should not provide opportunity for officers of nonprofit HMOs to enrich themselves by the transaction.

We will also hear testimony concerning HMO industry trends in order to consider how effective HMOs have been in containing growth in expenditures and providing quality care. Has cost containment varied by HMO type, whether it is an IPA, network, or staff/group model? Has the need for capital and the ability to raise capital differed among for-profit HMOs and nonprofit HMOs? Humana has stated the intention to provide a capital infusion of approximately $40 million. As a for-profit business, it clearly expects a return to its investors. What changes will Humana make to achieve a profit in this market?

And, if HMOs are going to be relied upon to provide higher quality care at less cost for Medicaid patients, we had better inquire as to which types of HMOs have had experience in providing quality care to underserved areas and also have a solid record in cost containment.

Finally, witnesses will discuss how the proposed sale affects the availability of coverage, access to services, and quality of care for current GHA members in the region. In particular, what commitment is Humana making to the 8,900 non-group GHA members who would be most vulnerable. What has been the experience when Humana has purchased plans in other areas? Federal and local regulators with authority to review and approve transactions such as this one will discuss the adequacy of their regulatory authority.

The proposed sale of GHA to Humana presents a timely opportunity to review one transaction in light of nationwide trends. Today's hearing should help us gain a better understanding of what effects on quality, access to services, and ability to control health care costs will result if these trends continue and are accelerated through health care reform.

STATEMENT OF REPRESENTATIVE CASS BALLENGER

Mr. BALLENGER. Thank you, Mr. Chairman.

I personally am fascinated with the idea of having the chance to discuss with or listen to professional people that know from past history how these situations operate, because that is obviously one of the biggest issues we are facing in this country today.

The only thing that I would wonder about is it seems like we don't talk about anything but HMOs. As a businessman who has 250 employees in his own insurance plan back home, there is never a word mentioned about PPOs, which we have found to be most successful down in North Carolina. What we have already going here is going to be discussed a great deal, and I look forward to being educated more about HMOs.

Obviously, I am less than enthusiastic, since we found a better way to do it at home. I would love to hear what they have going here.

The CHAIRMAN. I would assure the gentleman, if he would yield, that it is in the nature of the administration's proposal, and I think that PPOs exist in the District. The residents of the District are served by a variety of styles, as I think they are throughout the country.

So I doubt very much if any alliance, as they interpret this, would not have preferred provider plans as well as staff model HMOs and all kinds of varieties in between.

I don't think that anybody is suggesting they are being exclusively served. I think HMO has become an art form which encompasses more than somebody with your knowledge of it would think of as an HMO.

Mr. BALLENGER. Well, I greatly appreciate that, and I look forward to the possibility. From what I have read about the President's plan, and obviously I don't know a great deal about it, but it seems to me exclusive in the areas that it puts forth and probably, in my philosophical view, would not necessarily fit what I have been looking forward to.

Thank you, sir.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Bliley, submitted for the record by Mr. Ballenger, follows:]

STATEMENT OF REPRESENTATIVE THOMAS J. BLILEY

OMAS J. BLILEY, JR.
7TH DISTRICT, VIRGINIA

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Statement of Rep. Thomas J. Bliley, Jr.

Hearing on Proposed Sale of Group Health Association

September 14, 1993

The purpose of this hearing is to examine the details of the proposed sale of Group Health Association to Humana and the affect of this sale on health care access in the Washington, D.C. area. This hearing seems a bit premature as we can only guess as to what the implications of the sale might be. We certainly will know more about the sale's affect a year from now than we do today.

What we do know is that Group Health Association has been in financial trouble for a number of years. An outside, independent consultant hired by both the GHA management and the membership committee found that GHA faced statutory insolvency. Membership has declined from more than 156,000 in 1991 to 132,347 as of last month, a drop of more than 15 percent. GHA eliminated 100 positions and cut $1.7 million in administrative expenses in 1991. In 1992, GHA eliminated another 200 jobs and cut $1.4 million in administrative expenses. GHA's market share has declined from 41 percent in 1984 to less than eight percent today. As GHA member and noted economist Robert J. Samuelson recently wrote, "potentially, GHA is in a death spiral."

But GHA management and members did not merely resign themselves to what appeared to be inevitable. With the assistance of the nation's largest company in health care financing, GHA considered alternative means for continuing health care coverage for its members. After

an extensive process of offer solicitation in which 13 organizations were contacted, including local and not-for-profit candidates, GHA selected Humana to become its partner in the Washington, D.C. area. Last month, the GHA membership overwhelmingly approved this transaction. The members of GHA, in considering the alternatives, acted in a manner which they believed to be in their best interest and ratified the proposed transaction by a 12 to 1 margin.

I understand the decision by the members to convert their organization from non-profit to for-profit status may be an emotional one. But that decision is solely theirs to make. They weighed the advantages and disadvantages and determined that they needed a change. Indeed, whatever else one may say about the affect this sale will have on the availability of local health care, it is clear that the members of GHA believe the sale to ensure their continued access to quality health care.

Nationally, we know that trends show a change in HMO enrollment. More than 41 million Americans belong to the $45.6 billion HMO industry. Health Maintenance Organizations provide health coverage to approximately 16 percent of the population, including over 1.6 million Medicare beneficiaries and 3.6 million Medicaid enrollees. According to industry figures, most people belong to HMOs which are federally qualified. Between 1985 and 1990, the number of non-profit HMOs declined from 256 to 188 while the number of for-profit HMOs increased from 137 to 368 over the same period. We know that staff and group HMO models are being outpaced by Network and IPA models. And we know that HMOs are large. Over 60 percent of individuals covered by HMOs belong to plans in which more than 100,000 people are enrolled.

These figures tell us that the experience of GHA here in Washington is repeated across the country. If the quality of services decline or the cost of premiums are not competitive, employers and individuals move to other insurers and take their health care dollars with them. That is the way it should be and should continue to be. I am highly skeptical that any government agency can duplicate the achievements of the marketplace in delivering the finest medical care in the world at competitive prices. It is short-sighted to look only at the cost of medical services. We must measure the value. The national issue of health care obviously carries far beyond the jurisdiction of this committee. Since the Chairman and I both serve on committees which will be in the center of the national health care debate, I look forward to engaging him in that debate in greater and more comprehensive detail at another time.

In closing, let me just note that when the Committee considered my omnibus anti-crime bill last year, the Majority opposed it on the grounds that the subject should be left to the local government. Thus, while the Majority and the Council have continued to idly stand by, the District's homicide rate is once again near record highs.

When it comes to health care, the Committee sees a problem which may need to be corrected. We apparently have overcome the unwillingness to act even when it is theoretically possible for the local government to act itself. I am therefore encouraged that the Chairman has not hesitated to take action and hope that this hearing signals a new approach for the Committee. I hope that we will consider legislation on its merits and not be stopped by some mistaken sense that the Home Rule Act precludes congressional action for all District matters.

The CHAIRMAN. Our first panel this morning will discuss the Internal Revenue Service tax conversion issues, and the Department of Treasury is represented by Michael Schultz.

I guess you are the panel, Michael. Proceed to enlighten us. If I knew exactly where you are—you are in the Office of Tax Policy in the Department of the Treasury. Are you an Assistant Secretary or Deputy Secretary?

Mr. SCHULTZ. I am an Attorney-Adviser in the Office of Tax Legislative Counsel.

The CHAIRMAN. Thank you very much. Why don't you proceed?

Without objection, today the prepared statements of all the witnesses will be included in the record in their entirety. They will be available to anyone who would like to see them, and I would encourage the witnesses to summarize or expand on their written testimony in any manner that they are comfortable.

Lead off.

PANEL ONE, CONSISTING OF MICHAEL SCHULTZ, OFFICE OF TAX POLICY, U.S. DEPARTMENT OF THE TREASURY

STATEMENT OF MICHAEL SCHULTZ

Mr. SCHULTZ. Mr. Chairman, and distinguished members of the committee, good morning. My name is Michael Schultz. I am in the Office of Tax Policy at the Department of the Treasury.

I am pleased to be with you today to describe the Federal income tax issues that can arise in connection with the purchase of a tax-exempt health maintenance organization or HMO. My remarks will relate to purchases of HMOs generally, and not to the particular transaction that has prompted this hearing.

Further, in discussing the tax issues that purchase of these organizations can present, I do not mean to make any suggestion regarding the frequency with which these issues arise in actual transactions.

A nonprofit HMO may be tax exempt under either of two sections of the Internal Revenue Code, section 501(c)(3) or section 501(c)(4).

Section 501(c)(3) exempts from income tax organizations that are organized and operated exclusively for certain purposes, including religious, charitable, and educational purposes. The promotion of health is a purpose that is charitable within the meaning of section 501(c)(3). Section 501(c)(4) exempts from tax organizations not organized for profit that are operated exclusively for the promotion of social welfare.

An organization can't qualify for exemption under section 501(c)(3) if any part of its net earnings inures to the benefit of any private shareholder or individual. Neither the Code nor the regulations define inurement.

A general definition of inurement, however, may be derived from the cases and rulings that have applied the inurement tax. In this regard, a benefit provided by an organization described in section 501(c)(3) to an insider, that is, an individual who is in a position to influence the organization's affairs, constitutes inurement unless the provision of the benefit furthers the purposes for which the organization has been recognized as exempt.

About one-third of the Nation's HMOs are exempt from Federal income taxes. The majority of the HMOs that are exempt qualify as social welfare organizations under section 501(c)(4). A few of the exempt HMOs, however, have been recognized as charitable organizations that are exempt under section 501(c)(3).

The Federal income tax consequences of a purchase of a tax-exempt HMO are not entirely clear. As I mentioned earlier, the concept of inurement lacks a precise definition. Further, the implications of a purchase of an HMO or the HMO's tax exemption is a developing area of tax law. The Treasury Department has not issued regulations or revenue rulings addressing these transactions.

Further, there are apparently no litigated cases that have addressed these transactions. By reference to general principles of inurement, however, it is possible to identify one set of circumstances that may give rise to concern.

A purchase of an HMO that is described in section 501(c)(3) may result in inurement if the value of the consideration paid by the purchaser is less than the value of the purchased assets; in other words, if the purchase is a bargain purchase, and if one or more insiders of the HMO have interests in the purchaser.

If the purchaser does not pay adequate consideration for the assets of the HMO, the purchaser obviously receives a benefit. This benefit would not represent inurement, however, unless an insider of the HMO shared in the benefit. Therefore, inurement would result from a bargain purchase only if the purchaser is an insider or an entity in which one or more insiders have interests.

If the purchaser pays adequate consideration for the purchased assets, the purchase would generally not result in inurement.

Mr. Chairman, this concludes my prepared remarks. I would be happy at this time to address any questions that you or the other members may have.

[The prepared statement of Mr. Schultz follows:]

STATEMENT OF

MICHAEL SCHULTZ

OFFICE OF TAX POLICY
DEPARTMENT OF THE TREASURY

BEFORE THE
COMMITTEE ON THE DISTRICT OF COLUMBIA

SEPTEMBER 14, 1993

Mr. Chairman and Distinguished Members of the Committee:

Good Morning. My name is Michael Schultz. I am in the Office of Tax Policy of the Department of the Treasury. I am pleased to be with you today to describe the federal income tax issues that can arise in connection with a purchase of a tax-exempt health maintenance organization, or HMO. My remarks will relate to purchases of tax-exempt HMOs generally and not to the particular transaction that has prompted this hearing. Further, in discussing the tax issues that purchases of these organizations can present, I do not mean to make any suggestion regarding the frequency with which these issues arise in actual transactions.

A nonprofit HMO may be exempt under either of two sections of the Internal Revenue Code: section 501(c)(3) or section 501(c)(4). Section 501(c)(3) exempts from income tax organizations that are organized and operated exclusively for certain purposes, including religious, charitable and educational purposes. The promotion of

health is a purpose that is "charitable," within the meaning of section 501(c)(3). Section 501(c)(4) exempts from tax organizations not organized for profit that are operated exclusively for the promotion of social welfare.

An organization cannot qualify for exemption under section 501(c)(3) if any part of its net earnings inures to the benefit of any private shareholder or individual. Neither the Code nor the regulations define "inurement." A general definition of inurement, however, may be derived from the cases and rulings that have applied the inurement test. In this regard, a benefit provided by an organization described in section 501(c)(3) to an "insider"--that is, an individual who is in a position to influence the organization's affairs--constitutes inurement unless the provision of the benefit furthers the purposes for which the organization has been recognized as exempt.

About one-third of the nation's HMOs are exempt from federal income taxes. The majority of the HMOs that are exempt qualify as social welfare organizations under section 501(c)(4). A few of the exempt HMOs, however, have been recognized as charitable organizations that are exempt under section 501(c)(3).

The federal income tax consequences of a purchase of a tax-exempt HMO are not entirely clear. As I mentioned earlier, the concept of inurement lacks a precise

definition. Further, the implications of a purchase of an HMO for the HMO's tax exemption is a developing area of tax law. The Treasury Department has not issued regulations or revenue rulings addressing these transactions. Further, there are apparently no litigated cases that involve a purchase of an HMO. By reference to general principles of inurement, however, it is possible to identify one set of circumstances that may give rise to concern. A purchase of an HMO that is described in section 501(c)(3) may result in inurement if the value of the consideration paid by the purchaser is less than the value of the purchased assets--in other words, if the purchase is a "bargain" purchase--and if one or more insiders of the HMO have interests in the purchaser. If the purchaser does not pay adequate consideration for the assets of an HMO, the purchaser obviously receives a benefit. This benefit would not represent inurement, however, unless an insider of the HMO shared in the benefit. Therefore, inurement would result from a bargain purchase only if the purchaser is an insider or an entity in which one or more insiders have interests. If the purchaser pays adequate consideration for the purchased assets, the purchase would generally not result in inurement.

Mr. Chairman, this concludes my prepared remarks. I would be happy at this time to address any questions that you or the other Members may have.

The CHAIRMAN. Thank you, Mr. Schultz.

I understand that there are some constraints about questions you can answer orally today because of some uncertainty as to jurisdiction among departments and the status of the law, so that some of your answers may necessarily suggest that you will subsequently answer the question in writing.

Is that correct?

Mr. SCHULTZ. That would be possible. Sure.

The CHAIRMAN. I trust you. Okay? You decide and I will wait for the letter.

In the area of private inurement, as you discussed, how do you make a distinction between incidental benefits to private individuals and private benefits which would be prohibited in the Tax Code?

Mr. SCHULTZ. Well, your question, I think, really refers to two different tests that are applied to organizations to determine whether they qualify as exempt under section 501(c)(3). The statute, that is, 501(c)(3), itself prohibits any inurement whatsoever, so that the notion of incidental inurement is something that doesn't fit easily with the exact language of the statute.

There is a separate test that is not included in the statute, but is articulated in the Treasury regulations, that says that an organization has to have a public purpose and can't have more than incidental private purpose or serve more than incidental private benefits.

That is where the references come into play as to whether private benefits are incidental, and this is not necessarily part of the inurement test; it is the test in the regulations regarding private benefit. That because it is not in the statute itself, that test probably derives in part from the inurement test and also from the test that—or from the language in the statute that requires that an organization be organized and operated exclusively for charitable purposes. That means, of course, that if the organization serves private purposes it is probably not charitable.

Now the position of the Internal Revenue Service in looking at whether benefits are incidental is that they should be looked at both quantitatively and qualitatively. That as you look at both the amounts involved and also whether the serving of the private benefit is somehow a necessary corollary of serving whatever the public purpose of the organization is.

This is an internal position that the Internal Revenue Service has taken. It is not a position that the Treasury Department has promulgated in any formal rulings or regulations.

But that is the guidance that exists out there in terms of determining whether a benefit is incidental and therefore would not violate the requirement that an organization not serve a private purpose more than incidentally.

The CHAIRMAN. Okay. See if I understand the rules of the road.

In California, and you may or may not be able to comment, recently a large nonprofit HMO, in effect, sold itself to a for-profit operation. There is some question about the valuation and a host of other things. But this was a nonprofit corporation that operated for a number of years.

Is it not the theory that whatever value that entity had or has basically belongs to the people of the State of California? In a sense because, I gather, the Federal Government doesn't go outside the State boundaries in these issues, the decision is that the attorney general or the Governor of the State should see to it that what is profit, if that operation were just to liquidate, would go to help everybody in the State.

It belongs to charity, and charity is the State.

Mr. SCHULTZ. Well, I can't comment on any particular transaction. I think I am familiar with the transaction you're referring to, and it has certainly gotten some attention. But because I am not sure I understand all of the relevant facts I can't comment on that particular transaction.

I also think it is probably inappropriate for me to comment on issues of State law. I think the Treasury Department is primarily concerned with Federal tax law, although there are certainly relationships between the areas of law. I would not be surprised to learn that State law in California has restrictions.

I think State laws typically do have restrictions on how the assets of a nonprofit organization can be used upon the dissolution of the organization. That may depend in part on the exact provisions of State law under which the organization was formed.

The CHAIRMAN. Let me say it another way. Any charity, I don't care whether it is an HMO or church—maybe a church has members—but a charity which doesn't have members, it just has a self-perpetuating board and is there to serve a community, and it goes broke or it dissolves or it sells or whatever happens, and it has a bundle of assets. The question is, to whom do those assets belong?

Isn't it generally considered—it would satisfy common law that those assets belong to the community, to the charity? It has to serve all the people whether it is—it is probably a State, possibly a smaller subdivision.

Mr. SCHULTZ. I think that is generally consistent with the tradition of charities.

The CHAIRMAN. Now, in this case we have a kind of a mutual co-op, a golden guernsey. I mean, it is where the people who are the patients, just like the policyholders of Prudential, belong.

Is that different, that type of structure? Do the assets, therefore, of this charity where there are members—and maybe they even get rebates like—well, let's take the Wright-Patman Congressional Federal Credit Union. I belong.

Let's say they liquidate. They get caught by the RTC for making bad loans to Members of Congress and they say [whistles], "We're going to liquidate." "It is a nonprofit organization," they say. Is that a different situation than just the kind of an amorphous charity where you have identifiable members, although going back in time you may not have a continuity of membership? Is that a different situation?

Mr. SCHULTZ. I really don't know enough about the details. I think that is primarily a matter of State law. If your question relates to how Federal tax law looks at those organizations, I can tell you that if they are exempt under section 501(c)(3), they are required to be organized as well as operated for a charitable purpose, and one of the elements of the requirement that an organization be

organized for a charitable purpose is that the terms of its charter, bylaws or other governing instrument must provide for the disposition of the assets of the organization on liquidation in a manner that's generally consistent with the organization's charitable purposes. So the assets would have to be transferred to another section 501(c)(3) organization or to the government for use in public purposes.

That is the extent to which the Federal tax law addresses this.

The CHAIRMAN. 501(c)(3) is different, then, than Prudential where the assets might belong to the policyholders. Even if a 501(c)(3), an HMO—that is a kind of a different relationship relative to its "members" than a cooperative, say.

Mr. SCHULTZ. Yes. Well, I think it is fair to say that an HMO that is exempt under section 501(c)(3) is exempt not because of its cooperative nature, although there are organizations, of course, that are recognized as exempt on that basis.

But in the case of an HMO that qualifies under section 501(c)(3), it qualifies instead because it is charitable, and that brings into play, as far as the Federal tax law is concerned, certain constraints on how the assets of the organization can be used both in operation and upon dissolution of the organization.

The CHAIRMAN. Are you concerned in any of these transactions about valuation?

Mr. SCHULTZ. Well, it is an issue, probably the clearest issue that arises, particularly in cases in which you have some of the same people on both sides of the transaction. I think that is the case that really gives the strongest basis for concern.

In those cases, it is very important to look at the valuation. Now, unfortunately, it is not an easy thing to get at. You know these organizations are not traded on any kind of market. You can't look at a stock price quote and get a value.

So it is a difficult process in trying to determine valuation. It is a tough factual question, but it is necessarily complicated, particularly when you have insiders of the HMO that are involved in the purchaser. That is something that the Internal Revenue Service would have to look at.

As I mentioned in my prepared remarks, if the purchase price is not adequate, does not fully reflect the value of the assets, then it can result in inurement, which can have implications for the organization's tax exemption.

So we are concerned about it and that is something that the Service could be looking at, particularly when you have the same people on both sides of the transaction.

The CHAIRMAN. What is the statute of limitations on these transactions?

Mr. SCHULTZ. I think in general the statute of limitations for any assessment of tax is 3 years after the filing of the tax return. I am not aware of any special rule that would apply in cases of this type.

The CHAIRMAN. Unless there was something which would be considered fraudulent in the valuation.

Mr. SCHULTZ. Perhaps. The other thing I should mention is that in terms of thinking about what sort of taxes might be assessed, the statute of limitations may not come into play because the position of the Internal Revenue Service is that they will revoke an ex-

emption retroactively to the time of the violation in issue. They wouldn't necessarily be looking back for it, but a number of years prior to the transaction that cause the violation.

The CHAIRMAN. Mr. Ballenger?

Mr. BALLENGER. I don't have a great deal because, luckily for me, I don't have a situation like they have in California that whets my interest a little bit more than others.

But in figuring a 501(c)(3) operation to be a nonprofit organization, do you allow a standard depreciation of assets?

Mr. SCHULTZ. Because an organization that is described in section 501(c)(3) is really exempt from taxes, the issue of a depreciation deduction is probably not one that comes up typically. I mean you think about depreciation in connection with measuring income, and we are talking, by definition, about an organization that is not required to pay tax on whatever income they may have however we may measure it.

Mr. BALLENGER. What I was thinking, though, is when an individual or corporation decides to buy a 501(c)(3) you have to estimate a value somehow.

Mr. SCHULTZ. Oh, I am sorry. Okay. Your question goes to the valuation of the assets.

Oh, sure. I think some notion of economic depreciation would come into play in valuation. It is different from what tax lawyers think. That is why I was confused at first.

Mr. BALLENGER. So that basically there would possibly be a profit available to somebody if you paid depreciated value and the assets were worth more than the depreciated value.

Mr. SCHULTZ. I am not sure I understand. I thought the depreciation value was the value of the assets. I am not sure I understand the question.

Mr. BALLENGER. Quite often I think you find in business that it matters how the Federal Government allows you to depreciate. A lot of times they make you split it over 30 years.

Mr. SCHULTZ. I see.

Mr. BALLENGER. It is not worth what you have. But if they let you have it over 7 years it has still a value that is not on the books anymore.

Mr. SCHULTZ. Right.

Mr. BALLENGER. Would it then be possible for a profit to be made?

Mr. SCHULTZ. Well, I think the best way to answer your question is to point out that whatever rules that the government prescribes for depreciation really relate to this notion of computing the income of an organization.

Mr. BALLENGER. Right.

Mr. SCHULTZ. So they really apply only to organizations that have to pay tax on their income.

There are no set rules for depreciation or any other matters in determining the value of a nonprofit organization in connection with this issue that we were talking about a moment ago—that the chairman alluded to—that the valuation is at issue, because if the purchaser of an organization underpays for the assets, that can create possible inurement.

But in figuring out that value, we don't have a detailed set of rules in the way that we do for computing the income year by year. Any rules that the Government has issued for depreciating assets over certain periods of time do not necessarily apply for purposes of valuation. So you wouldn't run into a circumstance where there was some prescribed value determined by methods of depreciation that would necessarily be controlling in determining a purchase price or assessing market value.

Mr. BALLENGER. We have a fascinating situation, Mr. Chairman. Thank you very much.

The CHAIRMAN. Thank you very much, Mr. Schultz. You have been very helpful.

Mr. SCHULTZ. Thank you, Mr. Chairman.

The CHAIRMAN. Our next panel will discuss industry trends with relationship to growth, cost control, and quality issues: Mr. Robert Brand, who is the President of Solutions for Progress, former deputy commissioner of health for the city of Philadelphia, and a former member of the Pennsylvania Health Care Cost Containment Council; and Dr. Linda Peeno, former medical director for an HMO in Kentucky and affiliated with Citizen Action in Kentucky.

I welcome both of you to the committee, and perhaps you would like to proceed in the order in which I called you.

Mr. Brand, why don't you lead off?

PANEL TWO, CONSISTING OF ROBERT J. BRAND, PRESIDENT, SOLUTIONS FOR PROGRESS, INC.; AND LINDA PEENO, M.D., FORMER MEDICAL DIRECTOR, HUMANA, INC., KENTUCKY

STATEMENT OF ROBERT J. BRAND

Mr. BRAND. Well, let me begin by saying that there is a good reason for the people of the District of Columbia and the members of this committee to be concerned about a purchase of a valued health asset by Humana Corporation, given the experience of Humana in the health sector.

I am just trying to find my notes.

We have to remember that Humana pioneered in the production of and installation of artificial hearts as a marketing gimmick until they were stopped by the Food and Drug Administration, 1984 to 1986. They installed four Jarvik-7 hearts. None of the patients lived very long. Normal process of transplant technology made it very clear that these were unwise procedures when they began, and finally the Food and Drug Administration cut them off.

This is the same corporation that opened chains of Med First emergency centers to provide access to people for nonemergency care and then sold them when they proved unprofitable, leaving considerable gaps in the access patterns in community after community.

This is the same firm that spent 4 percent of the total advertising revenues spent by hospitals in the Nation in 1986, although they owned 1.5 percent of the hospitals. It is a chain that has done a great deal of work in providing physician incentives to under treat patients by withholding a portion of the physician's income until the end of the year to look at utilization patterns.

It is a chain that has been identified in study after study with under staffing of its acute care hospitals. It is a chain that has developed captive health insurance plans in which patients were relieved of deductibles if they were admitted to Humana hospitals, and in 1990 such captive plans made up 20 percent of Humana admissions.

It is a chain that made $650,000 on its Gold Plus Medicare Plan and was found in study after study by investigative reporters and government authorities to have refused to authorize treatment for serious medical problems, to have engaged in improper marketing practices in which people enrolled in the Gold Plus Plan did not know that they were losing their Medicare benefit.

The CHAIRMAN. I gather that you have no financial relationship with this company. [Laughter].

Mr. BRAND. Well, they did not pay my way here. [Laughter].

But actually it is the scurrilous practices of firms like this that keep me in business.

The CHAIRMAN. Okay.

Mr. BRAND. This is a company that has a long history of looking for health opportunities that make it a profit and considering patient care and community needs second.

However, I come here today to really say that the problem is much larger than this, because the "corporatization" of health care has gone on for the past 15 years uninterrupted and is now here to stay.

Let me start by reminding people of what the HMO and managed care sector looks like in the United States today. First of all, there are 553 HMOs in the United States at the end of 1991; 346 of them are individual practice associations, the least organized form of managed care and the form that is most questionable as to whether it saves any money for the total community.

The ratio of HMOs in 1974 was 70 percent group practice and 30 percent IPAs. At present that ratio has virtually reversed. So the largest form of managed care delivery and the most rapidly growing is the form that benefits communities least. The Congressional Budget Office Staff Memorandum of June 1992 cites all of the studies that show this.

Second, the managed care sector is consolidating. I don't mean in any way to demean the pain and the fears of the people of Washington, DC, but this is a national phenomenon. From 1970 until 1987 the number of HMOs in the United States grew from 174 to 647. Since 1987 the number has been shrinking in a process of mergers and acquisitions, and that process is continuing. At present 10 HMOs in the United States, 7 of which are for profit, enroll 53 percent of all HMO enrollees in the United States.

Voluntary enrollment in HMOs is decreasing. Despite the enormous financial pressures that people have on them to choose managed care alternatives, from a high growth rate of 36 percent in 1986, growth has slowed to 6.1 percent in 1989 and 5.2 percent in 1990. The American people are not choosing managed care programs of their own volition.

HMOs are concentrated also in densely populated regions where they focus their marketing on the suburban and affluent areas

within those regions; 56 percent of HMOs in 1989 concentrate in the 30 largest metropolitan areas in the country.

Their growth is very differential regionally. In the Pacific States, Middle Atlantic and South Atlantic States there was growth of over 25 percent per year in recent years, but only 1.1 percent in the Midwest.

Next, for-profit HMOs are increasingly dominating the HMO sector. Nonprofit HMOs are disappearing in the process of mergers and consolidations at twice the rate of for-profit HMOs.

Next, the HMO market is simply not a stable market. It is not just that we have a problem here of an attempt to buy an HMO. If Humana wants and if other companies want they can simply wait for this HMO to reach a point of financial nonviability, because the level of HMO failures and mergers and acquisitions is substantial.

For example, from 1980 to 1990, there have been 178 HMO failures; 148 HMO mergers; and 147 HMO acquisitions in a total universe that never exceeded 633——

The CHAIRMAN. Are any of those numbers duplicated?

Mr. BRAND. It is not clear. I am trying to track it. I suspect that an HMO that fails in year 1, is acquired in year 2 and then merges in year 3.

The CHAIRMAN. Okay.

Mr. BRAND. So I suspect there is some considerable duplication here. But it also goes to show that a substantial portion of this sector is in constant flux.

In addition, managed care is a rapidly growing source of insurance company profits and premiums; 25.3 percent of 1990 premium income came from managed care in the insurance industry. The share of revenues has grown from 0.3 percent in 1982. In addition, we now have Blue Cross and Blue Shield plans that are openly talking about shifting their entire emphasis to managed care through spinoffs and for-profit subsidiaries.

For example, Blue Cross of New Jersey is now a statewide PPO. That is its entire existence. In my State, the largest Blues plan goes around—has its sales force going around telling people that within 3 to 5 years they will be entirely out of the indemnity business and only in the managed care business.

So this is an issue that is national in scope and it is not as simple as for-profit/not-for-profit. I cite in my testimony an example of a current lawsuit between Health Management Alternatives, the for-profit company that runs the HIO experiment in Philadelphia, and Children's Hospital of Philadelphia—a, ostensibly, not-for-profit hospital—in which Children's Hospital alleges that Health Management Alternatives has a policy of cutting a day of utilization here or a half-day here or this procedure and that procedure, and thus under reimbursing the hospital for legitimate, necessary medical care, and has made over $30 million in profits and has attracted attention from this body and numerous other government investigating bodies for its high rates of profits.

HMA counterclaims, in the press at least, that Children's Hospital, the charitable institution, made $47 million profit in its last fiscal year.

Both of these corporations, one not-for-profit, one for-profit, exist and serve a community in which the two census tracts with the

highest infant mortality rates in the city of Philadelphia exist. These profits, whether they are in the not-for-profit sector or the for-profit sector, are at the expense of the lives of our children.

Simply stated, neither institution, while they have numerous charitable activities and while the for-profit one has set up a foundation to do charitable, good works, neither of them has made a dent in infant mortality rates that are staggering within the United States, and shameful and entirely preventable. Both of them, in my mind, share that burden equally.

There is no secret in the United States about how to make a profit in health care. We have all known this. It is not even hard. If you want to make a profit in health care all you have to do is serve healthy people and avoid sick people. If you avoid the elderly, if you avoid minority groups, if you avoid people who have kids who have chronic illnesses, you will make fantastic profits in health care.

The world of managed care has learned from the insurance industry how to avoid patients. The PPOs actually are the best at it because they are the least regulated. But the entire managed care industry has learned that by location, by recruitment of physicians, and by marketing practices, they can make vast sums of money by shifting the burden of health care to someone else or just shifting it to increased mortality and morbidity.

The clear implications of this is seen in the types of cases that we have been collecting in an initial set of focus groups that we have been conducting in Philadelphia with hospital social workers, where we ask about the current problems that consumers are having in managed care plans, and what we have found includes the following:

We found a patient with chronic obstructive pulmonary disease who is so debilitated that they were unable to leave their home. The treating physician had a therapeutic process of training the patient to use oxygen, with a portable oxygen tank, which would take a several-day hospital admission. The HMO denied the admission. The patient's condition deteriorated.

She was admitted as an emergency admission. The treating physician immediately moved the patient to his unit so he could start training so that this person would be able to be ambulatory. The HMO denied the training and simply paid for the emergency department admission.

We found a family that had a child with special health care needs who needed a very difficult leg brace, and this family, to protect their kid, since both adults worked, had two HMOs. They found in one HMO, finally, a doctor who could properly diagnose the child and fit the proper brace. That HMO does not cover leg braces. Not covering leg braces, by the way, is an easy way to send a signal to families with kids who need leg braces to go elsewhere.

The second HMO, however, would cover a single leg brace, and so they went to the second HMO and the second HMO said, "Yes, but that doctor is not on our panel. We will not pay for his diagnosis and his measurement of the brace." For months the HMOs fought with one another. The child remained in a wheelchair.

An 18-month-old child needing a prosthesis was told that the HMO they were involved in would cover one prosthesis—because, of course, we all know children do not grow.

Finally, a case of HMOs that market. In a Medicaid market, they get people to join who have hemophilia, but they do not cover treatment for hemophilia. Hospitals in Philadelphia are now eating the cost of $300,000 a year for hemophilia treatment which the HMOs simply ignore.

The way in which Humana could easily make a killing in Group Health Association is to buy and simply change the patients. I mean, again, this is an old HMO. It has older patients. But it has a group of doctors, it has a group of hospital relations, it has a good reputation in this community.

It is easy to market this plan in suburbs. It is easy to identify the doctors who take care of the sickest patients. It is easy to ease them out, to ease patients out, and to amend benefits so that those in most need simply find this not a useful place to get health care. Humana will have a very profitable entree into the Washington, DC community.

We did a survey in preparation for this testimony of a half dozen States to see how they are capable of regulating managed care. What we found, I should say, is that there are two States—New York and North Carolina—that have obviously paid considerable attention to how to regulate managed care programs.

In fact, the North Carolina Department of Insurance is now heading a national study to develop criteria for regulating PPOs. But we also found considerable lack of skill in regulating managed care.

The CHAIRMAN. Mr. Brand, I am going to have to bring out some of this in questions. You might like to get to your conclusion here. Then we'll have to move along and hear Dr. Peeno.

Thank you.

Mr. BRAND. Our conclusion is that there is a clear necessity for the Federal Government to look at the criteria for regulating managed care programs and to look at specifically issues of predatory competition, issues of marketing practices that would exclude people of color, poor people, people with chronic health care needs, and to look at data systems that look at preventable mortality and morbidity as a way of controlling and regulating HMOs.

Finally, that there is an absolute need to look at the issue of consumer roles in policymaking, not just at the health alliance level, but at the actual point-of-service level and at the ownership-of-plan level, in managed care systems.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Brand follows:]

Testimony of Robert J. Brand
Before the Committee on the District of Columbia
The Honorable Pete Stark, Chairperson

The Sale of Group Health Association and
Trends In the Corporate Structuring of the Health Care Sector

Introduction: The Corporatization of Health Care

Good morning, Mr. Chairman, and members of the Committee. My name is Robert J. Brand and I am president of Solutions for Progress, Inc., a small consulting firm doing work mainly on health care policy for trade unions, legislative bodies and occasional private clients. Prior to starting Solutions for Progress I spent nearly 20 years in the development of public health programs and policies in the non-profit private sector, in the public sector, and in the trade union movement. I have been involved in the development of emergency medical services systems, the assessment of public health programs, the development of public-private ventures to support public health programs and in a range of analyses, studies, and problem-solving groups in hospitals, nursing homes, and HMOs. I have served as Deputy Health Commissioner of the City of Philadelphia and have chaired the Pennsylvania Health Care Cost Containment Council. For several years, as Director of Health Care Policy for the National Union of Hospital and Health Care Employees and as a Senior Researcher at the Service Employees International Union I specialized in working with health care institutions with financial difficulties.

In working with dozens of hospitals, more than 100 nursing homes and with HMOs with millions of subscribers, as well as in the negotiation of health care benefits and cost containment programs, the inclusion of HMOs and PPOs, covering hundreds of thousands of insured lives, I have seen a troubling "corporatization" of the American health care sector close up. The very language we use to talk about health care has changed over the past 20 years.

> The "health care sector" has become the "health care industry."
> "Health services" have become "product lines."
> "Hospital administrators" have become "CEOs," "COOs", "CFOs," and the like.
> "Health planners" have become "marketing directors."

As professor J. Warren Salmon puts it, "Over the past several years the hospital industries trade magazines have extolled the necessity of changing their historical role through diversification into 'new markets'. Forward looking hospital executives are urged to partake in long-range strategic planning, set up 'profit centers', and seek out 'captive distribution systems' to guarantee patient flow. Nonprofitable patients are not to be 'targeted' in marketing new services." [1]

Corporatization of the health care sector produces an emphasis on profits, on market share, on investment opportunities. Service and community need are defined as the "demand function" for health care. And, as we know, a demand that cannot be paid for gets little response from the marketplace, especially if there are alternative investment opportunities available. Defenders of the evolution of a more market driven system, who believe that the corporatization of health care produces a social benefit argue that competition produces a downward pressure on health care prices and an efficient distribution of resources.

The purpose of my testimony today is to present evidence about the nature and effect of changes that have occurred in the health sector. My work suggests they are changes in which the small "tail" of for-profit health delivery has wagged effectively the rather large "dog" of the non-profit voluntary, community-oriented health care sector. In the past two decades, and especially since 1981, with the rhetoric that the marketplace will solve all of our problems, we have seen a health sector develop that is capable of elaborate market segmentation but is not capable of cost containment. We have seen a health sector grow that can pay fabulous salaries to administrators and fabulous profits to contractors but can not provide coverage to 37 million Americans at all and can provide only inadequate coverage for an additional 50 million Americans. In short we have seen a "marketplace" created which has torn asunder the community base of our health delivery system.

In this new health care marketplace "successful" institutions, hospitals and insurers that do not take care of poor people or particularly sick people, have become very wealthy, as have their management staffs, while the shared base of community services has largely disappeared from the health care sector. In short, the for-profit sector rhetoric of profits, market segmentation, targeting "winners" and not targeting "losers" is rapidly becoming the rhetoric and, unfortunately, the behavior of the not-for-profit health care sector as they are forced to compete for patients and fiscal solvency with the for-profit sector.

With this change the health care of the American people is at great jeopardy. For those with special needs, for those who are poorer than most, for those who are sicker than most, we are creating a health care system that actively discourages their treatment, because these are patients who cannot be as profitable as other patients. For the rest of us we are creating a system which is too costly to maintain, as competition prevents the sharing of services and the development of publicly accountable cooperative arrangements to share expensive equipment, facilities and procedures to the benefit of patients and communities.

For-profit models of economics, management, compensation, investment and structure are becoming normative throughout the health sector. As R.W. Rhein stated, "the corporate chains' success has elicited a compliment from the non-profit sector: imitation. Non-profit hospitals are also forming multi-hospital systems and there are now 225 non-profit systems that manage 1131 hospitals. 'The same ingredients that propel such companies as Sears, McDonalds and Exxon are also applicable to the institutional health care sector...' stated an officer of the Hospital Corporation of America." [2]

The proposed sale of Group Health Association, Inc. to Humana, Inc. is soundly in line with the trend of corporatization of the U.S. health care sector. I wish I could say that this is a unique situation, but it is all to frequent and common. The corporatization of HMOs parallels the organization of nursing homes, specialty hospitals, diagnostic equipment providers, physicians' practices and multi-hospital organizations, in fact all parts of the health sector. The health sector is becoming a competitive, market oriented sector, just as our health policies have directed it. The results, however, are not the salvation of our health system we might wish., as the following recent example illustrates.

In Philadelphia today we are witnessing the height of corporate arrogance from industrial giants in both the not-for-profit and the for-profit sectors. Children's Hospital of Philadelphia (CHOP) has Sued Health Management Alternatives (HMA), a for-profit HIO -- an involuntary managed care network for poor, mostly minority Philadelphians who are Medicaid beneficiaries. The suit charges that HMA practices a system of retroactive and partial denials of inpatient claims designed to minimize payments to the hospital. The suit alleges that each denial is planned to be too small for the hospital to take corrective action against HMA.

CHOP reminds us in their public statements that the profits of HMA were more than $30,000,000, causing studies and reports from federal regulators. HMA then reminds us that CHOP, a charitable hospital, made $47,000,000 profit in the last fiscal year. CHOP has also received press attention in Philadelphia for it $400,000 per year compensation package for its CEO and the $600,000 interest free loan it made to him so he could purchase a home. This obscene orgy of profiteering takes place in a community with the two highest census tracts in Philadelphia in terms of infant mortality -- with rates similar to impoverished developing countries.

Who is right on the merits of the suit is irrelevant. What is relevant is that a fabulously profitable charitable institution and a fabulously profitable managed care program are unwilling or unable to coordinate their resources for the benefit of the community they get rich by serving. The result is that our children simply and unnecessarily and quietly die. Both institutions have other priorities -- profits. And our public and health policies do nothing to change these facts.

Paul Starr, who won a Pulitzer Prize for his book *The Social Transformation of American Medicine* described five trends that accompany the growth of corporate medicine.[3] They are:

1. Change in type of ownership and control,
2. Horizontal integration,
3. Diversification and corporate restructuring,
4. Vertical integration, and
5. Industry concentration.

We are currently seeing all of these trends evolve in the development of managed care systems. We are seeing larger, for profit HMOs and PPOs, usually sponsored by insurance companies, buy, merge with and come to dominate their market areas. We are seeing small plans replaced by larger plan, replaced by still larger plans. We are seeing an alternative delivery system created as a national delivery system with virtually no oversight.

Trends of Managed Care Corporatization

First, let me state some of the facts of the trends in HMO ownership and organization.

1. **Managed care systems are growing in the least regulated, least accountable and least cost containment oriented forms.** There were 553 HMOs in the United States at the end of 1991. 346 of them (63%) were individual practice associations (IPAs) and 168 were group model (30%). In 1974 the ratio of group model HMOs to IPAs was 70% group to 30% IPAs, a virtual reversal of the composition of HMOs in the nation.[4] The distinction between group model and IPA model HMOs is important to note because the IPA models continue to rely heavily on fee-for-service reimbursement of physicians and rationing of access to care through utilization review processes. They are associated with no proven record of cost savings.

In June of 1992 the Congressional Budget Office issued a Staff Memorandum on "The Effects of Managed Care on Use and Costs of Health Services.[5] They concluded that "(t)he available evidence suggests that group and staff model HMOs can have a significant impact on use and costs of services for their enrollees, *although these effects may not lower system wide costs.* Research on independent practice association model HMOs and PPOs is more limited ... (and) suggests that these forms of managed care may reduce use and costs, but there is much less certainty about this conclusion..."[6]

The CBO Memorandum lists several alternative explanations as to why cost savings for a managed care plan might not be reflected as system wide cost savings, including "higher administrative costs for managed care, shifting of costs from the segment of the population covered by managed care to the segment of the population not covered by managed care, or insufficient interest on the part of health care buyers in obtaining services for the least cost."[7] Other researchers[8] raise questions of the different impact of different kinds of managed care programs, methods of provider payments and selection, and the issues of cost savings versus cost shifting.

What becomes clear from the total body of research on HMOs and PPOs is that we do not know if they actually save money system wide. It is very possible that all they do is market to healthier, employed people and then use their market leverage to get price discounts which are reflected as cost shifts, not savings. The reduction in hospital days per 1000 population associated with managed care may simply reflect a re-arrangement of health care funds, rather than a system wide savings.

2. **The managed care sector is consolidating.** The total of 553 HMOs in 1991 represents a continuation of the consolidation of the sector. From 1970 until 1987 the number of HMOs grew from 174 to 647, with the IPA model experiencing the fastest growth.[9] Since 1987 the number of HMOs has been shrinking through a process of mergers and acquisitions, a process which shows every sign of continuing. This consolidation represents a predictable restructuring as financially weak HMOs are driven from the market and as investment interest by national firms intensifies, spurred by health care reform efforts focused on managed competition. At present 10 HMOs, 7 of which are for-profit, enroll 53% of all HMO enrollees in the United States.[10]

3. **Voluntary enrollment of consumers in HMOs is decreasing, despite the enormous economic and employer generated pressure on consumers.** HMO growth in subscribers is slowing down. From a high growth rate of 36% in 1986 growth has slowed to 6.1% in 1989 and 5.2% in 1990.[11]

4. **HMOs concentrate in densely populated regions in which they focus their marketing on suburban and affluent areas.** HMOs and HMO growth differ by geographic area. The very presence of HMOs is largely a phenomenon of metropolitan America with 56% of HMOs in 1989 concentrated in the 30 largest metropolitan areas of the country.[12] Growth is highest in the Pacific, Middle Atlantic and South Atlantic States (over 25% per year), but is only 1.1% in the Midwest states.[13]

5. **The for-profit HMO is increasingly dominating the HMO sector.** Non-profit HMOs are disappearing in the process of mergers and consolidations at twice the rate of for profit HMOs. In 1990, non-profit HMOs shrank 16% and in 1991 12%, while for-profit HMOs shrank by only 6% and 7% during the same periods.[14] Enrollment in non-profit HMOs similarly is shrinking while for-profit HMOs are growing.

6. **The HMO market place is not stable with failures, acquisitions and mergers occurring with regularity.** HMO failures, mergers and acquisitions affect a substantial minority of HMOs in any given year. From 1980 to 1990 there have been 178 HMO failures, 148 HMO mergers and 147 HMO acquisitions in a total universe that never exceeded 633 plans according to data provided by Interstudy.[15] Failures and mergers concentrate in IPA model HMOs and seem to be present in both local and national HMO plans.

7. **Managed care is rapidly growing as a source of insurance company profits and premiums.** The commercial insurance industry and the not-for-profit insurance industry (the Blues) are rapidly shifting their emphasis and resources into the managed care market. The commercial insurance industry in 1990 earned 25.3% of its premium income from managed care, approximately two thirds of which came from the less regulated and less documented PPO market. This share of their revenues has grown from 0.3% in 1982.[16] Commercial insurers owned 43% of HMOs nationwide and enrolled 27.2% of HMO enrollees in 1990.[17] Increasingly Blue Cross/Blue Shield plans are shifting their emphasis to managed care

through spinoffs, subsidiaries (usually for profit) and through simple reorganizations. In New Jersey for instance the Blues now operate as a statewide managed care network. In Pennsylvania the sales force of the largest Blue plan openly tell consumers that within three to five years they will drop their indemnity plans entirely in favor of managed care "products."

The drive for concentration, consolidation and profit oriented corporatization in the HMO area is not at all surprising. It may be destructive. It may even be lethal to citizens with serious medical needs, but it is precisely the health system behavior we have asked for by not making health care a right for all people. We have told health care institutions to compete, to pay attention to the bottom line, to mimic the business practices of the wider society. Then when they do what they are asked to do we get a glimmer that maybe we have asked the health system to do the wrong thing.

<u>How Profits are Made in Health Care:</u>

It is a simple fact, widely known by people who work in the health care sector, that it is easy to make profits in health care. If you take care of affluent people you will take care of people who are more healthy. If you can separate the sick from the very sick, if you can treat the healthiest part of any category of "sick people" you will make profits. If you avoid treating certain categories of people – people with disabilities, people with chronic illnesses, people whose work poses immediate and long term health risks, people who are poor or who, in this society, are minority group members -- your costs will be less than your income. Given reimbursement systems that are basically averaging systems, any mechanism which separates people allows you to make profits.

Health care has always been based upon extensive cross-subsidization. People who are healthy subsidize people who are sick. Again, all of us who work in the health care sector know that a small percentage of patients use the vast majority of heath care resources. If any provider system minimizes their contact with these persons, and continues to get paid based on an average cost basis, they will make great profits. However, the providers who then act ethically to provide care where it is most needed will be deprived of the cross-subsidies.

Managed care plans which understand this reality can easily avoid money losing patients and thereby be profitable. They simply gear their marketing to avoid certain communities. They simply recruit certain doctors and hospitals but not others. They build a network that is simply inaccessible to the people they want to avoid and the profits are guaranteed.

The discriminating variable is not for-profit vs. not-for-profit ownership. The discriminating factor is the commitment of a provider to a single class of care for all consumers at a cost that is affordable. This commitment is simply not rewarded in a competitive market place. On the contrary ethical providers who believe health care is a right are losing, losing resources, losing the capital needed to serve, to expand, to meet real health needs.

Managed Care and the Restriction of Care

We have begun to conduct focus groups with hospital social workers. In these focus groups, we collect case studies on the problems people encounter in managed health care settings. The case studies we are collecting are *only the tip of the iceberg*. We have heard about patients' experiences with private health maintenance organizations including U.S. Healthcare (and HMO of PA and NJ) and Keystone Health Plan, as well as public HMOs (Medicaid managed care) Health Management Alternatives (HealthPass), Health Partners and Mercy Health Plan. In both private and public managed care, we see that the structure of managed care often discourages access to necessary health care and diminishes the quality of care patients receive.

From the initial sample of case studies we collected we grouped the problems into the following categories:

1. The reluctance of managed care plans to pay for physical therapy and other treatments that do not cure a chronic illness but that allow patients to lead more normal and productive lives, thus discouraging a person or family from continuing enrollment;

2. The HMO practice of using a general practitioner as a "gatekeeper" who must approve all procedures and referrals to specialists, often limiting the patient's access to specialty care;

3. The failure of some HMOs to pay for durable medical equipment such as wheelchairs and walkers sending a clear message to the chronically ill;

4. The loss of freedom of choice of physicians, especially the choice of specialists for serious conditions, again sending the message that if you need a doctor we do not include in our panel you either make do with who we offer or you find another plan;

5. Problems getting home care; and

6. Problems getting doctor-recommended procedures, medications, or blood products.

The following case studies are repeated over and over in every community where consumers are forced into managed care settings by economic considerations rather than as a choice of quality-based health care alternatives. We believe that there is important data about the problems which currently exist for people in HMOs. This data will not be released by the HMOs, or by the people who are advocating the wholesale imposition of managed competition on the American people. However, this is important information for people who care about the quality of health care in this state and country.

Case #1: A patient with chronic obstructive pulmonary disease (COPD) was so debilitated that she was using oxygen at home and was unable to leave her home except to come to her medical appointments. There is available treatment that would allow her to become more active and have a quality of life much above her present status.

However, her HMO continuously claims this treatment is not covered by her insurance. A physician at a participating hospital in her HMO network trains people on bi-level positive air pressure machines (BIPAP) which they then take home and use as required. This therapy allows patients to spend less time in the hospital and be more active.

This therapeutic admission to the hospital was denied by HMO-A. The patient then suffered a COPD crisis that could have been prevented by the prophylactic stay. She was admitted to the hospital through the emergency department, for which HMO-A paid.

The doctors then moved her to the specialized unit for BIPAP training, believing that now the treatment was more important than ever. HMO-A denied coverage for the entire stay on the unit and would only pay for the one day that the patient was on a medical/surgical unit.

Case #2: We received several reports about problems which occurred because HMOs will only cover 60 days of physical, occupational, or speech therapy. For example: A child was discharged to her home on a ventilator. She needed physical therapy at home. Her HMO would only cover 60 days of therapy. After the 60 days of therapy were over the HMO refused to pay for continued therapy even though the child was still in need of therapy. The social worker attempted to help the child continue her therapy with an early intervention program but these programs offer infrequent therapy. The child needed to be in therapy over a period of years in order to improve the quality of her life. This child did not get adequate physical therapy to meet her needs given the professional judgment of her physicians, social workers and therapists.

Case #3: A family was covered by 2 HMOs, HMO-B and HMO-C. The family has a child with a serious, chronic illness requiring leg braces. The family found a physician who could properly diagnose the child and properly measure the child for braces in HMO-B. HMO-B, however, would not cover the necessary leg braces. HMO-C would cover the braces but would not honor the diagnosis and prescription since the child was seeing a HMO-B pediatrician. The family did not want to switch doctors. The case, as far as the social worker knows, was never resolved. The HMOs just fought back and forth.

Case #4: A four-year old child with burns was referred by her primary physician to a specialist. However, when the burn specialist prescribed special dressings and antibiotic cream, the parent found she could not fill the prescriptions at her designated pharmacy unless her primary physician rewrote them. The pharmacy told the child's mother that they would not honor the prescriptions. They told her that she had to take the child back to the primary care physician. Unfortunately, she could not do that since the primary physician did not have office hours again for two days. The child could not wait for three or more days before starting the treatment with the antibiotic cream.

The hospital used their own supplies and emergency funds to make sure that the child was cared for; but by this time, the parent had run from one end of the city to the other in an attempt to care for her child.

Case #5: An 18 month old child required a prosthesis. This child's parents had HMO-B coverage. The child was growing and needed a larger prosthesis. The HMO would only pay for the first prosthesis but not subsequent ones. With braces and prostheses it makes no sense to limit availability to a single time. People, especially children, grow. Their needs change. Limiting a child to one prosthesis is essentially making it impossible for the family to continue as HMO enrollees.

Case #1: Standard treatment for a person with hemophilia is very expensive, often costing $300,000 per year for blood products alone. One teaspoon costs $1,500 and a person with hemophilia needs about 3-4 teaspoons per week. This life-saving treatment is required from birth to death, and there are no alternatives. This medication would obviously bankrupt nearly any family.

A pediatric hospital blood bank is forced to subsidize the cost of these blood products since HMOs will not pay for blood products. Medical assistance will pay. However, when people unknowingly switch from Medical Assistance to Medicaid managed care, the blood bank is forced to incur the cost of blood products without reimbursement.

The message to all of these families, patients or consumers is "If you are sick, go elsewhere. We treat the profitable patient only. If your needs exceed the average we will make you unwelcome or unwell".

Risk, Competition and Health

The guiding principle of the insurance industry, the industry that is increasingly controlling the marketplace for HMOs and PPOs, is "(a)ctuarial fairness -- each person paying for his own risk." Such a concept "is a method of organizing mutual aid by fragmenting communities

into ever-smaller, more homogeneous groups and a method that leads ultimately to the destruction of mutual aid."[18] Commercial insurers "provide for pooling of risks and mutual aid among policyholders, much as social insurance does, yet they select their policy holders, group them, and price their policies according to market logic."[19] In a managed care environment they will be constantly drawn to segmenting their markets and choosing profitable clients, unless prevented from doing so.

The mechanisms to segment the market are obvious:

1. Location: Contracting with some physicians and hospitals but not others; emphasizing marketing and provider recruitment in some areas but not others. Focusing on an affluent, insured, white area which is not convenient to public transportation assures a more affluent, assured, healthier, more profitable patient base.

2. Recruitment: Recruiting physicians who treat affluent people and "de-marketing" to physicians who treat sick people, poor people, uninsured people, people who are HIV+, people with treatment resistant Tuberculosis, people who have gunshot wounds or knife wounds will produce a core of doctors who treat patients who are easier to treat and less costly to treat.

3. Marketing "Priorities": Simply avoiding poor people as Kaiser HMO or US Healthcare have, by avoiding or minimizing participation in Medicaid contracts, and by avoiding any participation in paying for the care of the uninsured, gives you a leg up on profitability.

These are but the most simple and obvious of the market segmentation mechanisms used in the corporatization of American health care. Of course we would be remiss if we did not add the role of insurance companies in excluding people by profession, by location, by previous medical conditions,and by individual medical histories.

The corporatization of health care poses several serious policy questions for Congress, for state legislatures and for the American people. We have to decide what we believe the heath care sector is. If we decide that it is an economic activity just like any other sector of the economy, then these examples cited are not problems. However, we then must recognize that health care inflation will remain uncontrolled.

More importantly we will have to continue to accept the disparity of mortality and morbidity by race and class so prevalent in the United States. Mortality and disease by race and class will continue and that we will face an increasingly polarized society with substantial differences in a two-class health care system. We will continue to have low birth weight births be 110% higher for African-Americans.
Neonatal mortality will continue to be 97% higher for African-Americans.
Maternal deaths will continue to be 3.3 times higher for African-Americans.

Childhood Tuberculous will continue to be 4 to 5 times higher.
Childhood Anemia will continue to effect between 20 and 33% of African-American children.
Hypertension will be more than 10 times higher for African-Americans and diabetes 33% more prevalent.
Heart disease death rates will be 1.25% higher for African-Americans and stroke rates 80% higher.
These same statistics will be reflected for poor people of all races, given that we collect far better data on race than we do on economic class.

When we declare health care a simple economic activity we lose the ability to create appropriate incentives among providers and consumers to attack this disgraceful distribution of mortality and morbidity by race and class. If the incentive in the health care sector is to make profits, and profits are made by ignoring populations who are sicker who are more at risk, who are more needy, who cost more to take care of, then we lose the ability to target our precious health care resources on those who need health care the most.

The Issue for Public Policy

We must make a decision as to whether we want health care costs to be minimized. I suggest that health care is an essential social welfare service that must be universally available for the people of a society to be healthy, to be prosperous, to be competitive in a global economy and to pursue their individual and collective goals. We want to spend every penny we need to on health care and not one penny more. This should be a governmental goal, especially since government is by far the largest funder of health care. Especially given that universal health care is on the agenda of government, we should make clear that what we want is universal access to comprehensive benefits at the lowest possible cost.

If we want to let the market decide how much health care costs should be then we accept the economic disadvantage that every American business faces when competing in a global market with other advanced industrial countries who spend 25, 30, or more percent less on health care than the United States. If we believe that hospital administrators should be paid at the same rate as corporate executives of multinational corporations, then we create a burden for the productive portions of our economy.

We also have to decide if we believe that there should be local participation in the planning and oversight of the community-based health care system. If we determine that large national and multi-national chains are appropriate as the vehicles by which health care is delivered, then government has no pro-active role in creating policies to change this rapid evolution in our health care sector. However, if we believe that there should be accountability in a sector that is substantially not-for-profit and has its roots in community-based health care institutions, then we need to take effective action to preserve that type of health care system

and to create health planning and health care policy oversight models that reinforce such a system.

Therefore, we need to make a decision about what kind of health sector we want. If we want a community-based, not-for-profit, efficient, cost-minimizing health care sector, then government needs to aid in the creation of that sector. A sampling of existing government regulatory capabilities makes clear why federal action is necessary.

A Sample of Existing Regulations

The regulation of HMOs and managed care programs is weak and is fragmented with minor federal concern for financial failures and with major responsibilities given to the states. Unfortunately the states have an uneven record of even understanding issues of regulation of managed care. We conducted a telephone survey to show the inconsistencies and large gaps in the regulation of managed care programs. We found substantial differences between the states and substantial gaps in even the best states in our sample.

Overview of Survey Results

Five states and the District of Columbia were contacted to investigate the extent of regulatory oversight concerning the delivery of care to people living in poverty by managed care providers. These states were Pennsylvania, Vermont, New York, the District of Columbia, Ohio, North Carolina and South Carolina. The states oversight of HMOs generally was the purview of one or more departments, usually either the Department of Insurance or the Department of Health. Of the states we sampled only two carefully regulated HMOs in terms of attempting to ensure that HMOs provided service equally to poor people. The method used in both New York and North Carolina was to take maps of service areas and plot the location of hospitals and physicians offices to make sure that all areas are served. None of the other states contacted reported that they regulated HMO service provision to this extent. In fact, most of the other states we contacted did not even use criteria of special access needs to collect data, much less regulate licensure of HMOs.

State Summaries

Pennsylvania:

Regulation of HMOs and PPOs is shared between the Bureau of Health Care Financing (which looks at service issues) and the Department of Insurance (which looks at fiscal issues).

Pennsylvania requires HMOs to have "adequate" primary care specialists, but they do not investigate to see where the hospitals and doctors are located. The HMOs are required to report this information, so it could be examined. The Medicaid population is not supposed to be treated differently from private payers. However, the HMOs have few Medicaid enrollees, and "have to drum up business with the Medicaid population."

HMO profitability is not monitored.

HMOs are supposed to handle grievances internally before the grievant may go to the state. However the state is understaffed, and encourages the HMOs to resolve the grievances if at all possible. There are time "guidelines" for handling grievances, but these are not followed or enforced, perhaps because of the lack of state staff to intervene in a timely manner.

Ohio:

Regulation of HMOs is shared by three departments: the Department of Health (HMO Programs), Department of Insurance, and Department of Human Services for HMOs serving Medicaid population.

PPOs are not regulated.

The HMO Programs is only staffed by one person currently, and he can not perform on-site reviews more often than the once every three years as required by Ohio law. HMO Programs does not regulate coverage of poor people. DHS is supposed to do this. HMO Programs is supposed to certify that HMOs have adequate numbers of providers to serve the population they are certified for, for the services they have promised to cover.

The Department of Insurance is the last step of the grievance procedure. DOI will refer access and quality issues back to HMO Programs. DOI handles cost complaints. If HMO programs is getting a number of access or quality complaints about an HMO, they will investigate it sooner than 3 years.

They do not currently regulate PPOs. However, House Bill 28 will regulate PPOs. It was submitted in response to PHP (Physicians Health Plan) in Columbus trying to drop 3 hospitals. They were accused of dropping minority hospitals by minority physicians, and the bill was introduced to prevent these kinds of practices by PPOs and HMOs.

Vermont:

Regulation of HMOs is shared by the Department of Banking and Insurance, which regulates the company doing business, and the Health Insurance Rate and Forms Department, which regulates the product.

There is no regulation of PPOs.

There are no regulations to monitor HMO service, although a law recently went into effect requiring HMOs to serve everybody. Vermont Medicaid does not utilize HMO capitation agreements in Vermont. The state does not check to see if HMOs are serving poor populations.

They do track HMO profits, but they have no say in how those profits are used. They do not track the adequacy of HMO payments to providers.

Grievances are handled by HMO. The state tries to make HMO patients aware that they can also go to the state, but HMOs are not required to inform customers of this right. Grievances are supposed to be handled within a reasonable amount of time, but there are no mandatory time limits.

New York:

The Bureau of Alternative Delivery Systems is responsible for regulating HMOs. HMOs must have services that are of good quality and are accessible, and they must have providers in the areas where their service population resides, including specialists for all elements of the benefit package they contract for. The bureau will look at maps to see that there are sufficient accessible providers.

Profits are monitored, and profits over ten percent need state approval to be transferred out of health services. HMOs need to notify the state if they wish to transfer amounts exceeding 5% of profits out of health service provision. HMO payment rates to hospitals are regulated.

Grievances must be handled by the HMO within 15 days, and explanation of result must occur in a timely manner. Appeal to the state is available.

District of Columbia:

The Health Planning and Development Agency representative said that HMOs are exempted from service regulation. Privately purchased HMO products are not regulated in terms of consumer service. HMOs serving Medicaid patients would be subject to Medicaid regulation.

North Carolina:

HMOs are entirely regulated by the Department of Insurance. A Secretary in the Department of Health, when asked who regulates HMOs, responded: "What's an HMO?" The Insurance Department carefully follows their Examination Standards Manual for HMOs and PPOs, a proprietary document. HMOs are examined triennially, and when they want to make a significant modification of service, they must notify the state and are examined again at that point. This system has been in place for a year and a half. The state requires HMOs to make sure they have providers in all zip codes they service, and in all counties, as well as all parts of municipal areas. Maps are used to check this, and the state is sensitive to issues such as making sure that community housing areas have providers near by. HMOs can not be licensed if they don't have specialists in all areas including high cost services.

Profits are monitored, and HMOs must justify premium increase when they have high profits. The state attempts to balance between HMO solvency and service to the community. There are four HMOs that participate in non-profit voluntary programs to provide care to indigent homeless, although only one HMO takes Medicaid enrollees in the state.

PPOs are monitored, but the regulations are different from HMOs. However, in the future, PPOs will be under stricter regulation, once the NAIC comes out with the new standards for PPOs.

The grievance procedure is handled by the HMOs, and must be approved by the state. The State tracks complaints and uses them to regulate HMOs. The procedure can not exceed six months, and there is the option of 72 hour review for emergency cases, such as transplants.

Recommendations:

The issue before this Committee is how to prevent the loss of a substantial health care resource for the people of the District of Columbia. The issue before the Congress of the United States, in considering national health care reform, is similarly how to regulate a new and unproven health care delivery system to prevent a terrible loss to the people of the United States. The issue for public policy purposes is not the impact of for-profit corporate ownership of a single health care plan. That issue has been decided. Increasingly for-profit insurance corporations own or control most of America's HMOs. Given their vast wealth and ability to dominate marketing, there is every evidence that this ownership trend will continue, especially if a managed competition health care system is imposed upon the people of the United States.

The not-for-profit sector has learned to effectively mimic the for-profit sector, thus changing the question before us from one of whether profit-making institutions are acceptable in a health care system to the more evidence-based question of how to regulate the profit motive which is ubiquitous in health care and certainly in managed health care systems. Based upon our understandings, there is simply not an effective, state by state capability to regulate HMOs, and the faster growing form of managed care, PPOs.

Let us then look at some of the issues that are essential for regulators to examine. These issues will protect the subscribers to Group Health Association in Washington, D.C. from the profiteering record of Humana and would also be important protections for all citizens of the United States, to be considered as part of the national health care reform program.

First, there must be a consideration of **how a health plan addresses preventable mortality and morbidity within its primary service areas.** Such consideration would allow us to identify managed care programs which seek to avoid areas of high medical need and would allow us to differentially construct rates based upon medical need, rather than allowing for patient skimming and profiteering. If a managed care program seeks to serve people with substantially high medical needs, its rates should reflect that effort. In addition, over time, such a monitoring process would allow rates to be adjusted to reflect the success with which managed care programs actually address preventable mortality and morbidity.

Second, we need to introduce **data collection and regulations that will answer specifically issues of our continuing concern for the cost containment elements (if any) of managed care systems.** We need to assure that all managed care programs keep records of their ratio of costs of actual care to total premiums, the cost of administration, non-service costs and profits compared to premiums, and other indications of the indirect costs of care which are taken from the health delivery system.

There should also be specific reporting and data collection to determine whether HMOs save society by reducing total health care costs or whether they simply attract healthier, younger enrollees.

Third, **managed care programs should be evaluated in terms of their ability to lessen preventable hospital admissions.** Health systems should initially use ambulatory sensitive diagnoses as a beginning point for such studies.

Fourth, **managed care programs must be specifically regulated with regard to practices of predatory competition.** The segmentation of health care markets over time reinforces and rigidifies a two-class health care system. There needs to be strict guidelines for managed care programs to prevent competition by market segmentation.

Competition should occur in health care, but it should be competition to provide quality services at the lowest possible cost.

Regulations with regard to predatory competition should cover the recruitment of providers and the marketing of services to consumers. To the extent that communities are under-represented or health care institutions are under-represented (with at differential impact with regard to race) there needs to be specific regulation of the conduct of these institutions. The current rule that for each Medicaid recipient there must be at least three private-pay recipients is insufficient given the ability of large corporate health plans to segregate consumers by location.

Fifth, **attention needs to be paid to the access of people with special health care needs for specialty medical care.** The ability of health plans to exclude legitimate, high-need consumers by structuring its benefits, by disciplining its physicians or otherwise rationing care must be prevented. Basic protocols for access must be assured for all special needs diagnoses, including the ability to access physicians outside of the managed care network, if this is to the benefit of the patient.

Sixth, there needs to be significant attention paid to what are **acceptable ways of reimbursing providers in a managed care system.** We want to develop a health care system where we not only move away from fee-for-service reimbursement, but we also move away from incentive systems that reward providers for under-utilizing services.

Finally, we need to develop **specific concerns for public accountability within the health care system.** Within a relatively short period of time, the American health care system is transforming itself from an imperfect, but local, community based network of services in the voluntary sector to a profit-oriented, corporatized health care system. We will need to develop regulations to determine the role of volunteerism within health care institutions and to protect that role. We will also need to develop specific policy roles for consumers in managed care programs. Policy mediating roles in Health Alliances are insufficient to protect

the right to health care. We will need structures to guarantee a policy role for consumers at the point of service and at the corporate level of managed care programs.

These initial set of regulatory concerns are essential if the right to health care is to survive the corporatization of the health care sector. These protections are needed by the subscribers and beneficiaries of GHA in the District of Columbia and by every American. As the corporatization of health care has become a national issue, and as national health care reform flirts with strengthening untested and unregulated managed care systems these protections are essential.

1. The Corporate Transformation of Health Care: Issues and Directions, Baywood Publishing Co., 1990, J. Warren Salmon, p. 63

2. Medical World News (23) 3:54-64, 1982) (as quoted in Salmon, p. 62)

3. The Social Transformation of American Medicine, Basic Books, 1982, Starr, Paul p. 429.

4. Health United States, 1991 Table 135, page 293

5. CBO Staff Memorandum June 1992

6. ibid p. 15

7. ibid p.16

8. Miller, Robert H. and Luft, Harold S. Diversity and Transition in Health Insurance Plans, Health Affairs, Winter 1991, p. 45

9. Health United States, 1991 Table 135, page 293. Christianson, Wholey and Sanchez list a total of 679 HMOs peaking in 1988 in their Health Affairs article, State Responses to HMO Failures, in Health Affairs, Winter 1991.

10. American Medical News, May 25, 1992, p. 13

11. American Medical News, May 25, 1992, p. 17

12. National Underwriter, January 21, 1991, p. 19

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14. American Medical News, July 6, 1992, p. 21.

15. Christianson, Jon B., Wholey, Douglas R. and Sanchez, Susan M. State Responses to HMO Failures, in Health Affairs, Winter 1991, p. 85

16. Hoy, Elizabeth W., Curtis, Richard E. and Rice, Thomas Change and Growth in Managed Care, in Health Affairs, Winter 1991, p. 22.

17. ibid, p. 21

18. Stone, Deborah, The Struggle for the Soul of Health Insurance Journal of Health Politics, Policy and Law, volume 18, No. 2, Summer 1993, p. 290.

19. ibid, p. 292

The CHAIRMAN. Dr. Peeno?

STATEMENT OF LINDA PEENO, M.D.

Ms. PEENO. Good morning, Mr. Chairman, and members of the committee.

The CHAIRMAN. Before you go on, I made a grievous oversight. I did not recognize my colleague Ms. Norton, who has joined us. Good morning.

Please proceed.

Ms. PEENO. I thank you for the opportunity to be here today. You did not have a prepared statement from me in advance because I just got back from Argentina last night.

My name is Linda Peeno and I am a physician with specialty training in internal medicine and infectious diseases. Currently, I work actively in the field of medical and health care ethics and I am a student in a joint law and theology program.

I am also the executive director of an international academic on—society, for which I am the Chair of the Medical and Health Care Systems. I am a State and national board member of Citizen Action, a nonpartisan consumer group working on the health care issue.

I would like to make a note about the form that listed me as a former medical director of Humana. My work in administrative medicine began at Humana 6 years ago, which was as a part-time medical reviewer, a member of a 5-member physician team whose responsibility was to review medical necessity determinations for admissions and continued stay in the hospital.

It was my experience at Humana that led me to leave clinical practice and go into administrative medicine as a means of, hopefully, influencing some of the changes that were occurring in the health care industry.

From Humana, I left and was the medical director for 2 years of a local HMO which was a competitor of Humana, and then I was the medical director in the managed care division for Blue Cross-Blue Shield of Kentucky for a year. I was also the medical director of a 300-bed hospital in which I was the overseer of the management of Medicare patients.

It was my work in all of these areas in the field of administrative medicine that has eventually led me to study law and ethics, and I think this will become clear as I go on, because I discovered that in all this work a common task was required; that I was expected to use my medical expertise for the financial benefit of the organization, often at great harm to patients.

I discovered that the processes that I initially learned in my short time at Humana were usual and customary in the managed care industry, including management of the Medicare patients at the hospital level, which I don't think is being discussed today. What I learned was that Humana just did it better. They provided my combat training for the later work that I did.

I would also like to point out that I use managed care generically as all of those processes that have come together for the containment of cost and the influence of patient and physician behavior toward that end.

There are several trends about managed care which I believe should be part of our discussion but I am seeing rarely discussed, and I would like to mention four. But I will have only time to address my personal experiences with two, and will be glad to answer any questions.

First of all, the nature of the work that I did. By becoming a physician executive, I increasingly became aware that this is possibly an oxymoron, and I think the increasing numbers in this specialty should be examined carefully. These are physicians who receive high salaries. There are no standards for qualifications, no credentialing, no code of ethics, no oversight mechanism, and no understanding of what these professionals do. I can say that because that is the field that I chose to enter 5 or 6 years ago.

The second is the entrenchment of the management and production model for health care delivery that is captured in the managed care system. In this case physicians are often viewed as interchangeable parts in the process. They are losing the qualitative and quantitative values of close, long-term patient-physician relationships, which has tremendous consequences with regard to ethical decisions and problems in medicine and health care.

In addition, medical needs by the patients/consumers are viewed as isolated events to be managed and massaged as needed for profitability. There is little to no emphasis on the value of time, patient information and education, and privacy in our existing cost containment strategies.

The third thing that I am concerned about is the lack of genuine critical investigation of the mechanisms and logistics of what we call managed care—how these processes are really working and what they really accomplish.

When I first began my work as a medical reviewer, an accountant with this insurance company explained to me the simple arithmetic of my job: "We take in a premium. We use about 10 percent to run the business and we try to keep as much as possible of the rest. Your job is to help us do that." As a doctor working for insurance companies, I was to make decisions for the company's benefit, not for the patient's.

In my multiple areas of work, which went beyond Humana, I was involved in the design and administration of many processes whose goals were to achieve fewer payments of claims. Because some of these activities are little known, I would like to run through a list, and would not dwell on them but would be glad to answer questions about the ways in which they are used:

Benefit design in which you can exclude people simply by the nature of the benefits you draw up; pre-existing clauses, which we are familiar with; underwriting; marketing aspects; the network design; the choice of the physicians and providers with the right orientation incentives to restrict or even withhold care; technical and procedural design, which is often used in managed care organizations to create processes which are difficult for patients to even know or follow if they do know, so that payment of claims can be denied for lack of following the right route that was designed.

Information overload and uninformed consent.—The certificate of coverage by an insurance company, particularly a managed care plan, is treated as a contract and patients often have no idea what

is in this, particularly patients who are illiterate or can't understand the nuances of the language.

Rhetorical misrepresentation, where something is described, for example, as a comprehensive major medical plan but only pays 80 percent of the allowable amount of covered services, which is all very confusing to the consumers until they have to pay these costs. Separation between entitlement and receipt of benefits.—If you look in a standard insurance contract, you will see phrases like, "You are entitled to receive benefits for covered services as specified in the certificate." But receipt of benefits is subject to terms specified in the certificate, which means that the reviewers can make all kinds of determinations to their benefit.

Exclusions.—These often run up into pages. Our current Blue Cross policy has 84 exclusions. Most people are completely unaware of this or the implications of these.

Medical necessity.—This is managed care's gold mine, and this is where physician reviewers and physicians who work for insurance companies do their best work. It is the catch-all mechanism by which the insurance company defines itself as the final authority for determining if services or supplies are medically necessary. Of course, if they are deemed medically unnecessary, the insurance company does not pay for them.

Administrative discretion in which the insurance company or managed care plan retains the right to make decisions. Grievance and appeal processes which are rarely spelled out and are often confusing, and time spans are too short for people to act anyway.

Then retroactive review.— As an insurance doctor, I had an extensive arsenal by which I could do my work in all of these various jobs. In one company, I was expected to keep a minimum 10 percent denial rate and competed against other medical reviewers for the highest denial rate. In another position, my assessment included rewards and punishment. Punishments for success or failure with high cost cases.

On several occasions I was threatened with termination if I did not "get the numbers better." I was a good doctor to the degree that I was tough and profitable.

The fourth point that I would like to make has to do with our failure to anticipate the consequences of the systems that we are designing. One thing that I am particularly concerned about is a phenomenon that occurs in the hospital industry already called economic credentialing, which I think HMOs and PPOs are going to rapidly use, in which they will select physicians by economic criteria as representations of their efficiency. One of my projects as a law student has been to explore this area because I had great experience in manipulating statistics and determinations in order to make certain kinds of decisions about groups of physicians.

I would like to conclude with the end of a project that I did right on this topic that I think summarizes my concerns about the entire managed care industry. We must be cautious about inadvertent changes to the profession or practice of medicine, about the acceptance of fallacious notions of efficiency, about the abuse and misuse of quantitative and statistical information, and about the rhetoric of cost containment.

Ethics and justice claims are preeminent, for what appears to be justified economically may be costly in other ways and what appears to be a claim for social justice may be disguised real injustice.

I'll be happy to answer any questions.

[The prepared statement of Linda Peeno, M.D., follows:]

TESTIMONY

OF

LINDA PEENO, M.D.

BEFORE

COMMITTEE ON THE DISTRICT OF COLUMBIA
U.S. HOUSE OF REPRESENTATIVES
PETE STARK, CHAIRMAN

1309 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515

SEPTEMBER 14, 1993

OPENING STATEMENT

THE HONORABLE PETE STARK
CHAIRPERSON
COMMITTEE ON THE DISTRICT OF COLUMBIA

Good morning, Mr. Chairman and members of the Committee. I thank you for the opportunity to be here today.

My name is Linda Peeno. I am a physician with specialty training in Internal Medicine and Infectious Diseases. Currently, I work actively in the field of medical and health care ethics. I also am working on a joint degree program in law and theology. In addition, I am the executive director of an international academic society, for which I am the chair of its Medicine and Healthcare division. I serve on the state and national board of Citizen Action, a non-partisan consumer organization working on health care reform.

Please note that the witness list identifies me as a "former Medical Director" of Humana. Actually I was one of a five-member physician team organized to do medical reviews. We were the physicians who make medical necessity determinations for admissions and continued-stay requests. It was this experience at Humana which induced me to leave clinical medicine and move to "administrative medicine" full time. It was my hope that I could bring to the development and administration of health care policy my commitment to the care of patients in an ethical and humane way.

After leaving Humana, I was the Medical Director of a competing HMO in Louisville for two years. I also have been the Medical Director of a 300 bed hospital. I was with Blue Cross/Blue Shield of Kentucky for over a year in working in their managed care, legal and fraud and abuse divisions. It was the accumulation of all of my experience in "administrative medicine" that led me to my current work in law and ethics, for I discovered that all this work required a common task: ***using my medical expertise for the financial benefit of the organization, often at great harm to patients.*** I discovered that the processes I initially learned at Humana were usual and customary in the health care industry – Humana just did it with more sophistication, subtlety and profitability.

It is important to note that I use the term "managed care" generically to include all the processes and systems, both overt and covert, which are used to control costs, and influence patient and physician behavior. This includes hospitals' "management" of medicare, medicaid, and other fixed payment groups.

There are several trends in this business called "managed care," which I believe should be part of our health care reform discussions, but I see them rarely addressed. I will mention four critical ones, but will have time to address my personal experience with only two:

1. **THE RISE OF THE NEW PROFESSIONAL -- THE PHYSICIAN EXECUTIVE.**

This new specialty is increasing rapidly in proportion to the demand for physicians to assist organizations and hospitals to achieve positive "bottom line" results. They receive extremely high salaries, which are rarely mentioned in the discussions about physician incomes. There are no standardized qualifications, or credentialing process. There is no code of ethics. There is no oversight mechanism. Much of the success of "managed care" processes depends upon the work of these professionals as they make "medical necessity" decisions, influence physician behavior, and interpret medical information and statistics for use in financial and administrative decisions. There is little understanding about what they actually do, and it is an area which is completely unregulated.

2. **ENTRENCHMENT OF THE MANAGEMENT AND PRODUCTION MODEL FOR HEALTH CARE DELIVERY.**

Under such a model physicians are viewed as interchangeable parts in the process of the delivery of this product called "health care," losing the qualitative and quantitative value of close and long-term physician-patient relationships. Medical needs are viewed as isolated events to be massaged for profitability. There is little to no emphasis on the value of time, education and privacy in the existing cost-containment strategies. We should note that even at the economic level alone, the long-term consequences will be significant. More seriously, however, are the ethical consequences which will include problems that are well-known as well as others that will become more apparent, such as: the increasing conflicts between the ethics of corporate structures and the ethics of medicine; the difficulties generated by accelerated decision-making and the mushrooming of informed consent issues, the ethical implications in the design and implementation of the systems, etc.

3. **LACK OF A GENUINE, CRITICAL INVESTIGATION OF THE MECHANICS AND LOGISTICS OF "MANAGED CARE" PROCESSES AND SYSTEMS.**

We are not asking the critical questions: ***How do these processes really work?*** and ***What are they really accomplishing?*** When I first began my work as a "medical reviewer," an accountant with the insurance company explained the simple arithmetic of my job: "We take in a premium; we use about 10-15% to run the business, and we try to keep as much as possible of the rest. Your job is to help us do that." As a doctor working for the insurance company, I was to make

decisions for their benefit, not the patient's.

In the multiple areas of my work in "managed care," I was involved in the design and administration of the many processes whose goals were explicitly to achieve fewer payments of claims and increase in profitability. Because some of these activities are little known, I have drawn up a list of the questionable ways costs are controlled under the rubric of "managed care". I can testify that I have participated in each of these activities, and most of them were regular aspects of the work that I did in the managed care setting:

a. **BENEFIT DESIGN** in which benefits are restricted, reduced or eliminated in order to limit liability to a plan, for example changing the definition of "long term rehabilitation" from an extendable benefit based upon need and progress to a cap of 90 days.

b. **PRE-EXISTING CONDITION CLAUSES** in which claims are reviewed for "red flag" conditions that can trigger an investigation to determine if conditions were present before the date of insurance to avoid payment of a claim. For example, one trip to the ER for "chest pain," even with a diagnosis at the time of "gastritis," might be enough to deny payment for a $30,000 (or more) hospitalization for a "heart attack."

c. **UNDERWRITING** in which medical data, claims, or any other available information is used to avoid groups and individuals considered too high in risk.

d. **MARKETING** in which potential insurees are rarely given full information about a plan and its limitations and procedures, creating the many cases in which persons have had claims denied for failing to understand or know the plan in which they participated

e. **NETWORK DESIGN** in which "providers" are selected who have the right orientation and incentives to distribute, and if necessary, even withhold care.

f. **TECHNICAL AND PROCEDURAL DESIGN** in which "cost-containment" mechanisms such as 24-hour notice requirements, precertification, referral authorization, etc. are used to issues "denials" when the specified steps have not been followed.

g. **INFORMATION OVERLOAD AND "UNINFORMED" CONSENT** in which the "certificate of coverage" (COC) is viewed as the "contract" between the insured and the plan, even though there is no assurance that understanding and acceptance has taken place. The COC is usually a book averaging 50-75 pages. Not only is the importance of this rarely known or emphasized, it is usually written so that even well-educated persons with knowledge of legal and medical implications have difficulty deciphering its nuances. The procedures, qualifications,

definitions, and stipulations can be complex and confusing. To most people, especially those who are illiterate or have low levels of education, it is incomprehensible. No formal understanding and consent is necessary to make it binding.

h. **RHETORICAL MISREPRESENTATION** in which words do not reflect actuality, for example a plan called *"Comprehensive Major Medical"* may only pay *"80% of Allowable Amount of Covered Services."* This is rarely translated to insurees in real dollar amounts, which can be substantial and impossible sums of money for most persons, and rarely available in emergencies.

i. **SEPARATION BETWEEN ENTITLEMENT AND RECEIPT OF BENEFITS** in standard clauses in insurance contracts read *"You are entitled to receive benefits for Covered Services as specified in this Certificate. Receipt of benefits is subject to the terms specified in this Certificate."* Very few people understand that having the benefits does not guarantee payment for them.

j. **EXCLUSIONS** which are increasing in numbers, and are rarely seen or understood by insurers.

k. **MEDICAL NECESSITY** which is the "managed care" gold mine. It is the catch-all mechanism by which the insurance company defines itself as the *"final authority for determining if services or supplies are medically necessary,"* and those deemed "unnecessary" are not eligible for payment. Simple logic here explains the role of company physicians: A high salaried employee wishes to keep the job, keeping the job depends upon making decisions which are profitable to the company, therefore company physicians will push such determinations to extremes for the benefit of the company. Consumers have very little *effective* recourse when adverse determinations are made here.

l. **ADMINISTRATIVE DISCRETION** in which the range of action exceeds the explicit conditions in the certificate, and are established through clauses such as: *"Administrative policies and procedures establishes and/or adopted are used by us in interpreting and administering the provisions of your Certificate. The policies and procedures are binding upon you to the same extent as if they were stated in your Certificate."* In this way the insured are bound by additional materials and processes that can be confidential and ever-changing.

m. **GRIEVANCE AND APPEAL PROCESS** which is often unclear, or so restricted in time that is virtually unavailable to most persons.

n. **RETROACTIVE REVIEW** in which the claims which slip through all of the above processes can still be denied as an exercise of the administration of contract benefits, over which the insurance company has complete discretion. As one COC typically says: *"This includes without limitation, determinations on whether services, care treatment, or supplies are Medically Necessary,*

Investigation, whether surgery is cosmetic surgery, or whether charges are reasonable. Such a determination shall be final and conclusive."

As an insurance doctor, I had an extensive arsenal by which I could do my work. In one company, I was expected to keep a minimal 10% denial rate, and competed against the other medical reviewers for a "Christmas bonus" to be given for the highest denial rate. In another position, my assessment included rewards and reprimands for my success or failure with the high-cost cases. On several occasions, I was threatened with termination if I did not "get the numbers better." I was a "good" doctor to the degree that I was tough and profitable. I would have progressed in the business as a physician executive to the degree that I lost my primary ethical responsibilities to the care of patients.

It is important to note that current discussions to solve these problems with managed care actions will take more than requiring that companies take all comers and equalize prices. In fact, doing these things alone will force the managed care industry to seek other ways to avoid claims liability and payment, and increasingly sophisticated processes will continue to develop. The insurance companies will be left with *denials of care, undertreatment, avoidance*, and *lower quality* as their only tools to offset losses elsewhere. Even worse will be their use of these techniques to enhance profits. This is not a matter of speculation -- they already do this, and have continued to become better at such methods. There is no reason or current formulation that suggests that this will be offset or changed. We will be creating a system that characterizes what many have experienced already, in which they come to realize that: *"having insurance" does not mean access to care.*

WE ARE CREATING A SYSTEM IN WHICH WE WILL BE THE RECIPIENT OF ITS EFFECTS.

4. **FAILURE TO ANTICIPATE CONSEQUENCES OF THE SYSTEMS WE ARE CREATING.**

Although there are many aspects to this point, I will mention a phenomenon that is little known and understood, and is not a part of reform discussion. Like hospitals, managed care organizations understand that the "right" physicians are critical to their bottom-line results. The trend toward selection and pooling of economically correct physicians will become even more entrenched as plans struggle to keep costs within fixed budgets. The process, already known in hospital law as "economic credentialing," will become the tool of other organizations as they shift the assessment of physicians to economic criteria and data, selecting only those who are best suited for the plan's economic needs. The risk of adverse effects from this rises more in the managed care setting in which the incentives and disincentives can strongly encourage undertreatment, poor quality treatment, and even no treatment at all. Coupled with the "tools" mentioned in number 3 above, we can create a combination of forces with

disastrous potentials to the public.

I was prompted to my concerns for this issue by several professional experiences, including one in which I was required, under threat of termination, to use inadequate *and inaccurate* information to attempt to pressure physicians to change their practice patterns.

Each of these above areas raises very serious public interest concerns. The problems go beyond payment design and structure. There are additional ways to offset these problems that have yet to be a part of the reform discussions, e.g. defining and overseeing the new medical professional whose work is actively driving the medical/financial processes; enhancing the role of patient information and education as a means to influence utilization and inappropriate demands; approaching specific medical ethics issues which are emerging, etc. I do not have time to develop these in more detail, but could provide more during questions.

I would like to conclude with a paragraph from the draft of a paper I am completing (Overview of "Economic Credentialing": Health Care's Newest Disguised Injustice?):

We must be cautious about inadvertent changes to the profession and practice of medicine, about the acceptance of fallacious notions of efficiency, about the abuse and misuse of quantitative and statistical information, and about the rhetoric of cost-containment. Ethics and justice claims are pre-eminent, for what appears to be justified economically, may be costly in other ways, and what appears to be a claim for social justice may disguise real injustice.

Thank you.

ADDENDUM

Although my experiences can be easily dismissed as anecdotal, I can testify to many instances, in my many different positions as a physician executive/reviewer, that can support my claims about the usual and customary medical business in "managed care." The question should be raised: Why, then, are there not other physicians coming forward with the same testimony? I can only speculate: it is a very lucrative and easy field of work (no night call, reasonable hours, no patient contact, negligible worries about malpractice, etc.), and it is the one field in medicine assured of continued growth, especially in salary, with any health care reform using our current "managed care" processes. I am including two of the more troubling cases in which I was directly involved as examples of the untenable situations facing such doctors working in such contexts. I should note that there are many more of such examples, and in all these situations, I had no colleagues or support networks to assist me in determining the professional, ethical or legal course to take.

1. There are numerous cases in which I made unfounded medical denials. For example, a request was made by a physician to do an exploratory laparotomy on a patient whose medical condition warranted this surgical procedure. At first I approved it, but when the referring nurse (the first stage of denials came from the screening nurses, who were on a bonus system for "denials") called our supervising physician, he came to my office and instructed me to call back and say that we could not approve the procedure. My justification for doing this was to be that "we had insufficient data upon which to make the approval." This was a tactic we often used to stall the case. My supervising physician's reasoning was: this was a market in which the hospital was not owned. It was a "participating" facility, which meant that the insurance plan only had a small discount, rather than the deeper discounts in its own hospitals. We, the physician reviewers, had already been told to avoid as much as possible, any approval of services to these hospitals. In addition, the supervising physician said, the medical data suggested that this man had a rapidly progressing condition, and if we could "drag our feet," the patient may die while waiting for the surgery and we would not be out the cost of it. After we received more information, I eventually "denied" the procedure, which then forced the patient's physician to appeal and haggle with the insurance company. In the meantime, the patient died waiting for the determination that had been significantly delayed during all of these complexities.

2. A young nurse at a local hospital had a sudden onset of a progressive neurologic disease. After a lengthy hospitalization, she entered a rehabilitative hospital. Several weeks into her care there; one of the vice-presidents of the hospital, which was not only her employer, but also part owner of the HMO of which I was medical director, paid a visit to me. His charge to me was simple: the

woman's care was getting too expensive, and I was to find technical ways in the COC to deny continued payments for her claims. He wanted it to be based upon a "medical necessity" or a contractual reason, so that she would have limited recourse in her appeal. I was told that any medical decision I made would be upheld even if she appealed it. I was reminded that the key physicians on our appeal panel were so financially and politically tied to the interests of the HMO that they would not overturn any denial I made in this costly case. I refused to comply, for there were sound medical and contractual reasons to support the continued payment of her rehabilitative care. I was threatened with termination, and though it did not occur with this case, it created such tension that I knew my position was jeopardized and my continued stay was very difficult.

I am aware that these are dramatic examples. They are the extremes of what I did every day. I was expected to figure out a way to deny payment to anything that came to me for a "medical" review. On a regular basis I was told that we were not denying the treatment, only the payment of it. However, the reality in our country, under our insurance system, is that denial of payment means denial of treatment. I shudder now when I think of the numbers of inappropriate and inaccurate medical and administrative decisions I made in the interest of achieving certain bottom line results and professional acclaim and progress. Cases, such as the ones I have listed, are numerous in my experience. They continue to haunt me as I work actively to understand and change the systems which allowed them to occur. We face serious and unprecedented public interest problems here: the corporate health care forces are unleashed and evolving with little study or reflection as to how these processes are affecting moral and legal agencies and ethical values in medicine. We cannot ignore this in our health care reform.

The CHAIRMAN. Thank you both.

Dr. Peeno, is it fair to suggest that the types of risk selection or risk avoidance that you have outlined for management are not unique to any one particular HMO or preferred provider plan? That there is a state of art in the industry and that you could probably find in any one of the five major insurance companies who operate preferred provider plans the same type of risk avoidance or benefit revision? Is that a fair statement?

Dr. PEENO. Yes, sir. If I were to go to meetings in which there were topics discussed among medical directors or medical reviewers—right—these are states of art that have developed in the industry across the board.

The CHAIRMAN. There are some insurance companies who might even do things like sell you a 6-month policy to get you in, and then once you are in and they have a chance to review your medical records, in the subsequent renewal increase your premiums resoundingly.

I mean the practices probably aren't limited to the ones you outlined. Those would occur in the underwriting department, and you were in the claims adjustment—as we will call it—department. Is that correct?

Dr. PEENO. Yes, sir. One of my many tasks as the medical director of the HMO was to review reports from our marketing department, because they would do medical assessment evaluations on companies before we would sell plans to them.

The CHAIRMAN. Yes, and I wanted to ask Mr. Brand pretty much the same question. The kinds of situations which you have outlined in your testimony are quite common among the preferred provider plans throughout the country, are they not?

Mr. BRAND. Oh, yes. Absolutely. Without public accountability, they will just get more sophisticated over time.

The CHAIRMAN. Well, we'll see, although I must say that the administration in its initial proposal is attempting to deal with it. I am not sure they have adequately found all of the restrictions that will control it.

It's important for the hearing this morning to suggest that, while we are looking at a currently operating HMO in the District, these very same things could be going on in the current operation of this HMO, and thereby anybody who acquired them might continue those same practices.

I am not suggesting that they are. I am just suggesting that this is not an exclusive intellectual property of the Humana Corporation.

Mr. BRAND. No. But they made their money by being good at it.

The CHAIRMAN. Well, we all like to be good at what we do.

As I say, your testimony concerns me in a far broader context than the medical delivery system and how it will be affected in the District. It applies nationwide. It applies in Hayward and Oakland, California, as well as it would here or in Raleigh, North Carolina. These are concerns that we face.

We are dealing with a $900 billion industry and there are a lot of people who would like to get their hands on a big portion of that $900 billion, so it doesn't surprise me. But hearing specific examples, one suspects that these things go on—. While I am sure that

you will both hear your testimony dismissed as anecdotal, I have always said that I have a roomful of anecdotes, and that when you get to the point where you hear repeated anecdotes, in a large percentage of the cases those anecdotes become statistics.

It is important for the committee and the public to be aware, but I did feel that this was not a "Let's all pile on Humana" day. I suggest that Humana is perhaps no better or worse than the industry at large and may or may not indulge in the practices that you outline.

Mr. Ballenger?

Mr. BALLENGER. Thank you, Mr. Chairman.

I wonder if philosophically the two of you might agree that your professions were created in the seventies when the Federal Government decided to step in and start saying what costs were in the medical profession through the creation of Medicare, and that they have done such a fabulous job that your professions have gotten bigger and bigger?

Dr. Peeno, as an example, my own little company. We had an employee who was very sick. We didn't know what was wrong. He was in a local hospital. We were covered with insurance, and so the ambulance took him to a teaching hospital in Winston Salem where they immediately put him in surgery.

I don't know how much surgery or what was done, but in a period of 24 hours he died. Then we got the bill and the bill was $35,000. I said there's no way in God's green earth that you can tell me that $35,000 can be spent medically on somebody in 24 hours.

I was fortunate enough at the time to be on the study commission that was trying to figure out who were going to be the next insurers for the State employees' plan in the State of North Carolina. I was in the State senate at the time.

So I went to Blue Cross-Blue Shield and I asked them to reexamine this. That was my insurance carrier at that time. Would you reexamine this and explain to me how you can possibly spend $35,000 in 24 hours on one person. They reexamined the whole thing and then came back and said it was perfectly legitimate.

There was no way I could argue the point. I had no idea what it was, even if they had given me some kind of an explanation where I could have gotten with a lawyer. I probably needed another doctor.

But the basic feeling that I have had ever since is that the insurance companies don't really care what the costs are. This is when you are paying the premiums, you have your employees covered, and they don't care what it is. They just pay the bill and submit a higher premium to you.

Somewhere along the line I have come to the conclusion that the system has gotten to the point where they recognize that very few people look at the bills that they get because they are covered. I think everybody recognizes we don't have some sort of thing with coinsurance where at least somebody cares what the costs are, you are really going to be in trouble.

Finally, if I may just add a little bit. I don't know whether we have a PPO or HMO or what it is my company has, but we finally hired somebody to just spend all their time examining our bills, examining the service that we were getting. In a period of 2 years our

insurance costs have gone down 40 percent—just because somebody was looking at the way the money was spent.

We don't have Humana in there, so I am not going to beat up on Humana. But we do have a for-profit hospital in my community, and it is surprising the number of times that we have found overbilling. One lady came in for the delivery of a baby that went cesarean section, and again, just because we were interested enough to look at it, we looked at the bill, and the amount of IVs and blood that was given to her in a period of about 2 days. I said there was no way you could plug her in with both arms and continuously feed her all day, 24 hours a day and use that much stuff. They said, "Oh, my goodness! Did we do that? Well, let's just change that."

I often wonder how seldom people examine their bills. One of the major problems we have in this country today is the fact, I believe, that we don't even look at our own bills. We just turn it over to the insurance company and forget it, except if the premiums go up again immediately.

Having preached a sermon, go right ahead.

Mr. BRAND. It is true we don't have a mechanism to handle bills. I was involved in a union health plan where we had about 270,000 insured lives. We found that there were regularly given to us over 1 percent of claims that were perfectly valid claims but not for people who were any one of the 270,000 people who we were responsible for. We set up a unit just to control and look at bills. It was a money saver for us.

But the inefficiency of the billing practices of the American health care system shouldn't obscure the fact that health care is important. When I was involved in emergency medicine in Philadelphia, I used to watch $35,000 be spent in a 24-hour period all the time, and save lives doing it.

You get a kid with a burn, with serious burns, or you have a serious head injury in an automobile accident, you are going to spend tens of thousands of dollars even before you get that person to a stable hospital room.

The way in which we solve that problem—that health care can be so unexpectedly expensive—is what is before you now as a Nation. If we choose to solve it by saying, "Well, we're going to insure people and my job as an insurance company is going to be to figure out how to take the people who are least likely to incur those high costs and make them someone else's responsibility," and keep fragmenting and segmenting our population into profitables and the unprofitables, we will continue to waste tens of billions of dollars on health care.

But if we make health care a right of every person, and then try to figure out how to pay for it the most direct, cheapest way, that puts real controls on doctors and hospitals and pharmaceutical companies. We can not only have a seriously healthier population and prevent all sorts of unnecessary death and disability in this country, but we can give back to our society and our economy between $60 billion and $100 billion dollars a year.

Mr. BALLENGER. Could I ask a question?

Mr. BRAND. Sure.

Mr. BALLENGER. How do we give it back when it is $60 billion to $100 billion? Where does it come from? Just over expenditures at the present time? That is a pretty broad statement.

Mr. BRAND. It is the cost of having 1,200 insurance companies do the work of one.

Mr. BALLENGER. I was wondering where you were coming from. I thought you were coming from there but I wasn't quite sure.

But since we don't live in England or Canada, I figure we are going to at least play around with something a little bit different.

Mr. BRAND. If we want to waste money on insurance duplication and impose costs of insurance companies on every hospital and every doctor and every physical therapist and every social worker and every psychologist in America, then we don't have that money to spend on higher profits, and as a businessperson I am a little bit interested in higher profits; we don't have that money to spend on education; we don't have that money to spend on infrastructure; we don't have that money to spend on lower taxes.

If we continue to wait——

Mr. BALLENGER. Could I interrupt again and just ask, do you think if we took that responsibility away from the insurance companies and gave it to the Federal Government that we wouldn't waste more than what the insurance company is making in profits?

Mr. BRAND. Well, actually, the Federal Government has been very unwasteful in the administration of the Medicare program.

Mr. BALLENGER. What they have done is they just passed the cost onto those of us that pay our premium.

Mr. BRAND. Private insurance companies do contract work for the Medicare program all the time at half their administrative costs as when they do work in the private sector. The Federal Government can, if it chose to use its monopoly buying power, make efficient health care and live itself on a budget, and put the whole health system on a budget.

That would also have the added benefit of making the poorest and most sick among us have the same right and the same opportunity for health care as the richest among us, and that would be a tremendous boon for America. I mean this, and I didn't have time to go through it, but I include in my testimony a whole list of areas in which mortality and morbidity are distributed by race and class in this country, and it is totally unnecessary. We can fix those problems.

Mr. BALLENGER. If I could just interrupt again for a moment——

Mr. BRAND. Yes.

Mr. BALLENGER [continuing]. And be polite? I come from further south than around here. At least give the lady a chance. I mean, you monopolized the conversation.

Would you like to say something?

Dr. PEENO. He is doing pretty good.

I think the one point that he made about not allowing the inefficiency of the billing practices to obscure the more critical issues here is really important. It is also important to mention that some of the billing inefficiencies are the direct result of this very complicated administrative system that——

Mr. BALLENGER. Created by the Federal Government.

Dr. PEENO. Well, created by the way this health care system industry has developed. It is not just the Federal Government that a hospital has to deal with or that a physician has to.

Mr. BALLENGER. Generally speaking, you must admit that—at least where I come from, in the kind of agrarian areas of North Carolina—something like 80 percent of the money that is paid to hospitals comes from the Federal Government.

Dr. PEENO. Well, that may be true, but I don't think you can assume then that is the cause of the billing inefficiencies and the difficulties that we just talked about.

Mr. BALLENGER. I think the difficulties that we have created through the Federal Government help to create the billing inefficiencies.

Dr. PEENO. No. I wouldn't agree with that. I can use as an example my husband, who is in private practice, an OB-GYN, and mostly OB, who sees very few patients that are supported by any government money. The administrative costs for him to run his office haven't been generated by the Federal Government. That's just been generated by the fact they deal with 200 different insurance companies, and it is just a complex mess.

But still the point that I would like to make is that out of these processes have emerged ways in order to shift costs among different classes of people, providers, employers, and individuals. The health care industry uses the processes as a way to enhance the profitability, and this doesn't apply just to for-profit companies and hospitals.

I mean the hospital that I worked in, for example, is a nonprofit hospital with 80 percent Medicare patients. We utilized all of these same techniques that I talked about to manage the care of these Medicare patients, just like I did when I went to the HMO and managed the delivery of care. The goal was to make money—to bring in a person and figure out how much the DRG was going to pay and to limit their stay or do whatever was necessary so we at least minimized losses, but, hopefully, made money.

Mr. BALLENGER. Well, that was making money off of Medicare then. Right?

Dr. PEENO. The same principle.

Mr. BALLENGER. Yes.

Dr. PEENO. It is not my expertise to get into a discussion about whether it is better to have the Federal Government or private industry. I am mostly concerned about the practices and the consequences of medical decisionmaking on patients, because we are all going to be the victims of whatever health care system emerges from this.

It is going to change the nature of the patient-physician relationship and the way in which we receive care. I already see this among my colleagues. Everyone in my family are treated by my fellow physicians. I see this every day in the medical ethical questions that are emerging from these kinds of things, and that's my concern.

Mr. BALLENGER. Right. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Ms. Norton?

Ms. NORTON. Thank you, Mr. Chairman. I regret that I am due in Georgetown shortly to the dedication of a park. I find this testimony very important and appreciate that you have used this opportunity to bring forward a controversy, a kind of model controversy, I suspect, in the country. I only hope that when health care reform comes, we will be a model for that as well.

Perhaps I have time for a couple of questions. I would like to ask Mr. Brand, who gave compelling testimony about what happens in for-profit operations, and among the most compelling is what you had to say about infant mortality in Philadelphia.

I wonder if you are saying that profit versus nonprofit has to do with that difference. Do you believe that a nonprofit HMO, that there is any evidence that they have done better or do you believe they would do better given the costs and problems, some of them not related to the health care system, that are faced by our HMOs? Is the critical difference profit versus nonprofit?

Mr. BRAND. I think that actually the critical difference is no longer profit versus nonprofit. We have lost that battle. Our nonprofit corporations learn how to act from our profit-making corporations. They learn that if they want to go out to the bank and borrow $40 million to invest in facilities, they have to be just as cutthroat as our for-profit corporations.

Therefore, it becomes essential for us to think in terms of how to put the health system into an arena of public accountability. We know we can map mortality and morbidity in terms of preventable rates for any health service area in this country on a PC. You don't even need a smart machine to do this.

We can say to a Children's Hospital or to an HMO—or an HMA in Philadelphia—"You want to get paid at all, do something about infant mortality, do something about hypertension, do something about diabetes. We are going to measure you period after period and your rate of payment will be whether you helped make us healthier, and not how much you squander on yourselves."

Medical researchers will say, "Well, the state of the art of outcomes-oriented reimbursement systems is not fully developed. That is nonsense. For medical research they may not be fully developed, but for public policy purposes we could make every health plan accountable at its reimbursement point and at the point where consumers would form a board to say: "No, we're waiting too long. No, there are too many of us getting turned down. No, we are not being allowed to look for specialists. No, the specialist I need is not in this HMO. I joined this HMO because my kid has asthma and you have a good pediatric asthma group. But me, now I have cancer and I have to go somewhere else."

We could put in systems that allow that type of consumer policy role to be apparent. As the managed care system becomes predominant, and as managed care, which after all used to be a pro-consumer reform, becomes more competitive, more profit oriented and more responsive to the health care of the American people, the issue of how we regulate and how we legislate these things becomes more important.

I have to say, Mr. Ballenger, that when I hear people say, "Doesn't the government make this worse"—Well, if the govern-

ment made it worse, then it is time that the government fixed it, and you all are the government.

Ms. NORTON. Could I ask Dr. Peeno a question? I have to confess that I had never heard of administrative medicine until you coined the expression or mentioned the word. I think about a fair number of specialties that I don't think are going to be nearly as thriving as they once were, because I have no idea whether national health care is going to pay for a referral to specialties in a way that some health referrals are now made.

But you implied that this kind of referral is one that at least some physicians regard as interesting enough and lucrative enough to pursue. I think we need to know—at least I need to know—a lot more about administrative medicine. Could you tell me something more about it, such as whether or not large numbers of physicians are being attracted, whether it is a post-intern specialty, if it is considered a specialty? Does this have to be done by a full-time physician or could it be done by another kind of administrator with the help of a physician?

Dr. PEENO. I am very glad you asked that question. Several years ago administrative medicine, first of all, wasn't something that was used regularly. But there were physicians who worked in administrative capacities like executive directors of some hospitals and mostly in insurance companies. These were usually retired physicians who after years of practice, based upon their medical expertise and wisdom that they had accumulated over the years, could help with medical situations. There have been physicians who have joint degrees in MBA programs who did go into hospital administration.

I think that a coincident or a direct result of the managed care industry has been the rise of something that can actually be termed administrative medicine. Although I don't know the statistics on this. I have heard—I think it would be worth looking into—that the fastest growing physician organization in the United States right now is the American College of Physician Executives, which was started actually to meet the needs of the rising numbers of these physicians.

Now, when I started doing this kind of stuff I didn't know what administrative medicine was. I didn't intend to do this. I was moonlighting while my children were in college—I mean in high school, and had the opportunity to do medical reviews. I mean that seemed like a benign thing to do. My background was sufficient to render reasonable medical decisions. It was only when I became involved in that I saw emerging this entire field.

I did not have to, but I actually have my boards in utilization, management and quality assurance. I went through the 3-part course provided by the American College of Physician Executives. I took courses in health care economics and marketing, and all of that was by choice. There are no requirements to do this.

Now we have this emerging field of physicians who work for insurance companies, large employers, who are full-time physicians who do no clinical work but simply administrative, statistical, medical reviewers, people who do these kinds of tasks that this administrative system has generated.

I have a lot of concerns. These physicians are paid very well. When I left Blue-Cross, when I reached the point that I could not continue to do what was required of me in that capacity, I was making $156,000 a year for 30 hours a week work.

I know that there are physicians who do this kind of work whose starting salaries are $250,000 and up. Now, in all the media's reports about physician salaries you never see this group of physicians discussed, and these are the physicians who stand to benefit the most from the creation of an increasingly more complex managed care system in which you require physicians to run and oversee networks of physicians, make decisions, and do all of the business of health care as opposed to the clinical practice of health care.

Ms. NORTON. Thank you very much, Dr. Peeno.

Mr. BALLENGER. Mr. Chairman?

The CHAIRMAN. Mr. Ballenger?

Mr. BALLENGER. Could I ask unanimous consent to include Congressman Bliley's statement in the record?

The CHAIRMAN. Oh, without objection.

Mr. BALLENGER. Thank you.

The CHAIRMAN. The record will be open for 5 days for any other comments that people would like to make.

I would like to thank the panel very much. You have been very helpful. I appreciate your enlightening the committee.

Our next panel will deal more specifically with reasons or the events concerning the sale of the GHA HMO to Humana, and our witnesses will be led off by Mr. Robert Pfotenhauer, the chief executive officer of the Group Health Association; Ms. Betty Ann Kane, who is a member of the board of directors of GHA; Dr. Ronald Lankford, who is the senior vice president for medical affairs of Humana; and Mr. Harold Wool, who is the president of the GHA Member Rights Committee. I should identify Ms. Kane as a former DC City Council member, and Mr. Wool as a former president of the GHA Board.

The issues that I hope this panel will address for the committee deal with how this transaction will affect the availability of coverage and access to services, quality, the commitment that the purchaser is making to the non-group members, and the issue that has been discussed frequently about the need for additional capital and the commitment to provide it. Those are all areas that would be of some interest to us.

Why don't you proceed, Mr. Pfotenhauer, and we will have the other witnesses follow in the order they were called.

Thank you.

PANEL THREE, CONSISTING OF ROBERT P. PFOTENHAUER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH ASSOCIATION, INC.; BETTY ANN KANE, MEMBER, BOARD OF DIRECTORS, GROUP HEALTH ASSOCIATION, INC.; RONALD S. LANKFORD, M.D., SENIOR VICE PRESIDENT, MEDICAL AFFAIRS, HUMANA, INC.; AND HAROLD WOOL, CHAIRMAN, GROUP HEALTH MEMBER RIGHTS COMMITTEE

Mr. GREENBERG. Mr. Chairman, my name is David Greenberg. I am the chairman of the board of Group Health Association. This is a member-elected consumer board of trustees.

So I would like to just introduce Mr. Pfotenhauer.

The CHAIRMAN. Fine.

Mr. GREENBERG. Thank you.

As you may know, GHA was a pioneer in the now fashionable field of managed care. GHA was founded in 1937 and is one of the oldest HMO organizations in the country, and the oldest in the Washington area.

With me today in the room are several other members of our board, including Pam Smith, Annie King Phillips, Sherry Hemstra, and Betty Ann Kane.

Mr. Chairman, now I would like to introduce Mr. Robert Pfotenhauer, president and chief executive officer of Group Health Association.

STATEMENT OF ROBERT P. PFOTENHAUER

Mr. PFOTENHAUER. Mr. Chairman, thank you.

GHA is the oldest health maintenance organization in the Washington area, and was founded in 1937 by a group of Federal workers. Today, Mr. Chairman, GHA faces very significant competitive challenges and an extremely weak financial condition. This situation led our member-elected board to recommend that Group Health be sold to Humana in a recent vote.

In a record turnout last month, more than 37,000 of GHA's adult members voted overwhelmingly, with a 91 percent "Yes" vote, to sell substantially all of GHA's assets and liabilities to Humana.

The proposed sale offers the best opportunity for Group Health to continue affordable, quality health services to the 132,000 people in Washington, DC, Maryland and Virginia for whom we provide comprehensive medical coverage.

Granted, many of the pressures and changes in the health care marketplace facing Group Health are similar to those affecting other health plans around the country. But in the midst of the national debate on health reform, it would be a mistake to draw too many conclusions based on this proposed sale.

Neither should the proposed sale be misinterpreted as a failure of managed care or managed competition as models for national health reform. That is because there are several unique aspects of Group Health that make our situation separate and distinct from the debate on national health reform.

GHA is the only HMO out of more than 500 HMOs in the country that has a unionized medical staff. GHA is the only HMO in the country that has experienced two work stoppages by its medi-

cal staff and several years of labor friction between its consumer board, management and organized bargaining units.

Of all the HMOs in the Washington-Baltimore area, GHA has clearly the highest percentage of members over the age of 45. Unlike many of our newer competitors in the region, GHA cares for an older and sicker population of enrollees, many of whom have grown old with GHA.

It is no secret that we are facing a host of serious problems. We are losing market share. Our share of the Washington area HMO market has plunged from 41 percent in 1984 to less than 8 percent today. We are losing members at approximately the rate of a thousand members a month. That has existed now for nearly 2 years.

We have an extremely weak income statement, an operating margin of roughly 1 percent over the last 3 years, when the industry leaders have margins in the 4 to 6 percent range. We have very limited capital and very limited capability to add capital, and an extremely weak balance sheet.

We face new competition, and we have some of the highest premiums in the Washington area because we are taking care of an older, sicker population.

All of these factors led the member-elected board of trustees to the conclusion that the best solution to our problems was to recommend to members that GHA sell substantially all of its assets and liabilities to Humana. Before reaching that conclusion, however, there was nearly 36 months of exhaustive study and analysis and hundreds of hours of deliberations. Since last February we have also had discussions with 12 other national and local health care organizations and, I should add, both not-for-profit as well as for-profit—including Humana, obviously. The options included proposals to merge, affiliate, convert to a stock company, and, finally, to sell GHA to Humana.

An important part of the board's deliberations was what each bidder proposed with respect to GHA's vulnerable members, those who pay premiums out of their own pockets or for whom GHA is the sole source of health insurance. Members of the board felt a strong sense of responsibility to ensure that any sale proposal would protect such individuals.

Humana was very responsive to the problems faced by these members and has assured us that they, in fact, will be protected. In addition, individuals who are employed by small businesses in the District of Columbia and for which Group Health is the sole source of health insurance will have additional conversion protection that is not even provided by statute currently within the District.

Humana's proposal to buy GHA is a fair value offer which provides continued coverage for our members and allows them to maintain their physician-patient relationships. We believe that under a Humana-GHA plan premiums will become more affordable, new managed care and insurance products will be introduced, and new, more convenient service sites will become available throughout the metropolitan area.

In conclusion, the proposed sale of GHA to Humana has much more to do with continuing the security of health coverage for our 132,000 members than it does with issues related to national health care reform or whether for-profit medicine is better or worse than

not-for-profit medicine or whether managed care is, in fact, superior or inferior to unadulterated fee-for-service indemnity benefits. It is none of those issues.

At the heart of the matter is the deep-seated conclusion of the elected majority of our board that the security of health coverage for our members was too important to jeopardize. Mr. Brand, although I strongly disagree with much of his testimony, Mr. Chairman, made a very salient point in stating that had this situation continued it could have resulted in further deterioration financially of the organization, which frankly our board members were not willing to risk.

Thank you very much for the opportunity to testify.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Pfotenhauer follows:]

TESTIMONY

OF

ROBERT P. PFOTENHAUER
PRESIDENT AND CHIEF EXECUTIVE OFFICER

GROUP HEALTH ASSOCIATION, INC.
4301 CONNECTICUT AVENUE, N.W.
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BEFORE

COMMITTEE ON THE DISTRICT OF COLUMBIA
U.S. HOUSE OF REPRESENTATIVES
PETE STARK, CHAIRMAN

1309 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515

SEPTEMBER 14, 1993

Mr. Chairman, and members of the Committee.

My name is Robert P. Pfotenhauer. I am President and Chief Executive Officer of Group Health Association. GHA is the oldest health maintenance organization in the Washington area, and was founded in 1937 by a group of federal workers.

Today, GHA faces significant competitive challenges and an extremely weak financial condition. This situation led our member-elected Board of Trustees to recommend that GHA be sold to Humana, a large, publicly-traded managed care company. In a record turnout last month, more than 37,000 of GHA's adult members voted 91% to 9% to sell substantially all of GHA's assets and liabilities to Humana.

The proposed sale offers the best opportunity for GHA to continue affordable quality health services to the 132,000 people in Washington, Maryland and Virginia for whom we provide comprehensive medical coverage.

Granted, many of the pressures and changes in the health care marketplace facing Group Health are similar to those affecting other plans around the country. But in the midst of the national debate on health care reform, it would be a mistake to draw too many conclusions based on this proposed sale.

Neither should the proposed sale be misinterpreted as a failure of managed care or managed competition as models for national health reform.

That's because there are several unique aspects of Group Health that make our situation separate and distinct from the debate on national health care.

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GHA is the only HMO in the country that has experienced two strikes by its physicians and several years of labor friction between its consumer Board and bargaining units.

Of all HMOs in the Washington-Baltimore area, GHA has the highest percentage of members who are over the age of 45. Unlike many of our newer competitors in the region, GHA cares for an older and sicker population of enrollees, many of whom have grown old with GHA.

It's no secret that GHA is facing a host of serious problems.

- ✓ We are losing market share. Our share of the Washington-area HMO market has plunged from 41% in 1984 to less than 8% today.
- ✓ We are losing members at the rate of about 1,000 a month.
- ✓ We have had a weak income statement.
- ✓ We have limited capital and a weak balance sheet.
- ✓ We have more competition.
- ✓ We have some of the highest premiums in the Washington area.

All of these factors led the member-elected Board of Trustees to the conclusion that the best solution to our problems was to recommend to members that GHA sell substantially all of its assets and liabilities to Humana.

Before reaching that conclusion, however, there was 36 months of exhaustive study and analysis, and hundreds of hours of deliberations. Since this past February, we have also had discussions with 12 other national and local health care organizations. The options included proposals to merge, affiliate, convert or sell GHA.

An important part of the Board's deliberations was what each bidder proposed with respect to GHA's vulnerable members - those who pay premiums out of their own pockets or for whom GHA is the sole source of health care coverage.

Members of the Board felt a strong sense of responsibility to ensure that any sale proposal would protect these individuals. Humana was very responsive to the problems faced by our vulnerable members and has assured that they will be protected.

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In conclusion, the proposed sale of GHA to Humana has much more to do with continuing the security of health coverage for our 132,000 members than it does with issues related to national health care reform.

At the heart of the matter is the deep-seated conviction of the elected majority of the Board that the security of health coverage for our members is too important to jeopardize.

Thank you very much for the opportunity to submit these comments.

The CHAIRMAN. Ms. Kane?

STATEMENT OF BETTY ANN KANE

Ms. KANE. Thank you, Mr. Chairman. For the record, my name is Betty Ann Kane. I have been a member of Group Health for 23 years. As you know, I served for 4 years on the board of education. I have chaired the board of education's committee here that had oversight for health services for the DC Public School students, and from 1979 to 1990 I served as an at-large member of the DC City Council and was responsible for developing an entirely new health benefits program for District employees hired after September 30, 1987, who were, by congressional decision, no longer eligible to participate in the Federal Health Benefits Program.

In May of this year I was elected by the members to serve on the board of trustees of Group Health Association. I am currently chairman of a working group at the board that is dealing with the issue of how to set up a successor nonprofit after the sale of GHA to Humana.

I give you that background, Mr. Chairman, to let you know very clearly I am speaking today in my individual capacity as a former city official, a GHA member, and a board member, and that my views do not necessarily represent the official views in anyway of the GHA board or any other organization. But I do speak out of informed and some varied experience with health care in the District and with GHA.

While I agree with Bob Pfotenhauer that there are issues specific to the GHA-Humana sale, I think there are some lessons to be learned from the Group Health experience and implications for the future of health care service in the District under the President's soon-to-be revealed health care reform proposals.

As you know also, I was one of three trustees who voted against asking Group Health members to approve a sale of GHA to Humana this summer to which the members have given approval.

I am a strong believer in health maintenance organizations of the kind that GHA pioneered. Group Health Association set a model by providing for over 50 years quality, comprehensive prepaid service with an emphasis on prevention. Access to health care is not an unfortunate accident to insure against, but a service which all District residents should have available on a fair and affordable basis.

As you know, the District does not classify or regulate HMOs as insurance providers, and GHA's own "Articles of Incorporation" explicitly state that the organization's purpose is to arrange and provide services for its members. It is not organized as an insurance company.

I regret the loss of member control and the introduction of the profit motive that will result from this sale, and I also regret the conclusion reached in some quarters that the sale shows that so-called pure HMOs, which GHA was, can't succeed in the marketplace, so that only very large providers can be successful.

I think there are several lessons to be drawn for health care from the GHA experience which include (1) that health care should not be linked to employment status; (2) that health maintenance

organizations need to do a better job of communicating the advantages of prepaid comprehensive service; (3) specifically, that any health care system for the District under health care reform must be regional in nature; (4) that complete community rating is a necessity. Let me briefly elaborate on some of these points.

Number one, health care decisions are increasingly made by employers and not by consumers. The health benefits officer at the company who decides what plans or plan to offer to the employees becomes the client, and the needs and interests of the employer are not always the same as those of the individual. In particular, smaller health provider organizations like GHA can be particularly disadvantaged by this situation.

Number two, the issue of choice in doctors and other providers in HMOs is a red herring. The truth is that no one has a completely open choice of doctor, hospital or other service, except maybe someone who can totally pay their own cost.

All of the plans, as you revealed at your hearing last spring, Mr. Chairman, including the supposedly pure indemnity plans like Blue Cross, make decisions about which providers will be in their plan and therefore which people will have an access to it. I think that if HMOs are going to be part of the health care reform for the District and the country, and I definitely think they should be, there will have to be a sincere and concentrated effort to tell the story better.

Number three, health care providers serving the District must be regional in nature. One of the issues that GHA struggled with, for example, was how to raise capital to open service locations in the faster growing suburbs beyond the Beltway. Approximately two-thirds of the people who work in the District live in Maryland and Virginia. As long as health insurance remains employment linked, employers in the District will need access to health plans with service providers throughout the area. A strictly State-based system will also disadvantage the District because of the city's larger pool of lower income residents with higher costs and higher health needs.

Finally, community rating where everyone is charged the same amount for the same service is a necessity in order to fairly and fully serve the residents of the District. I give in my testimony, Mr. Chairman, an example of the fact that when I was a Government employee under the Federal Employees Health Benefits Program, which the District was participating in, the combined monthly premium for a family was slightly less than $300. During the 18-month COBRA period when I was able to stay on at the Federal rate plus a small administrative fee, this rose to only about $314.

But the minute the 18 months ran out and you go into the direct pay category, the premium went up by one-third, and a few months later by a net 50 percent. By the stroke of a statistical pen the same three adults in the exact same state of health went from one arbitrary grouping to another and paid 50 percent more for fewer benefits.

There are large numbers of District residents who are self-employed, who work for small firms, who are especially vulnerable across the current rating system. This is not something unique to GHA. It is the system that is out of whack here. Maryland, for ex-

ample, has recently enacted a community rating law, which I understand is designed to eliminate this kind of discrimination.

Finally, what is ahead for the GHA legacy and tradition for the residents of the District? The GHA Articles of Incorporation provide that "upon the dissolution of the corporation the board of trustees shall, after paying or making provision for the payment of all liabilities of the corporation, dispose of all the assets of the corporation exclusively for the purposes of the corporation in such manner or to such organization or organizations operated exclusively for charitable, education or scientific purposes that qualify as a 501(c)(3) organization under the IRS law."

In accordance with this, if members were promised that the sale to GHA would include the establishment of the association as a not-for-profit charitable foundation to be the guardian of the proceeds of the sale, and the information statement to the members provided along with their ballot said that the board of trustees is recommending you approve establishing a not-for- profit charitable foundation that will use the proceeds of the sale for scientific, educational or charitable purposes related to health care. The exact nature of this not-for-profit successor to Group Health Association will, of course, depend to a large extent on the ultimate size of the net proceeds that are left after the liabilities and contingencies are worked out in the sale. But I can assure you that as Chair of the board working group I will keep a sharp eye on the deal in order to protect as large an asset pool as possible for the possible successor nonprofit.

We have a work plan that includes outreach and consultation with the Group Health leadership, the members, and the larger community. We certainly welcome input in that process—I welcome input in that process.

Mr. Chairman, this concludes my formal remarks this morning. I look forward to working with you, and I would be happy to answer any questions.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Kane follows:]

Statement of Betty Ann Kane
before the
Committee on the District of Columbia
September 14, 1993
hearing on
The Implications of the Proposed Sale
of Group Health Association, Inc., to Humana, Inc.
for Health Care in the District of Columbia

Mr. Chairman, members of the Committee: My name is Betty Ann Kane. I have been a member of Group Health Association for 23 years. I served for 4 years, from 1974 to 1978, as an at large member of the D.C. Board of Education, and chaired the Board Committee that had oversight for health services for students in the D.C. Public Schools. From 1979 through 1990 I served as an at large member of the D.C. City Council, and chaired for four years the Council's Committee on Government Operations, whose jurisdiction included the health benefits programs for D.C. government employees. In this capacity I was responsible for developing an entirely new health benefits program for city employees hired after September 30, 1987 who were, by Congressional decision, no longer eligible to participate in the federal employees health benefits program. In May of this year I was elected by the members to serve on the Board of Trustees of Group Health Association. I am currently chairman of a working committee of the Board that is dealing with how to set up a successor non-profit after the sale of GHA to Humana.

I am speaking today in my individual capacity. My views do not represent the official views of the GHA Board or any other organization. I speak, however, out of informed and varied experience with health care in the District and with GHA. I thank the committee for the opportunity to appear before you and share those views. I hope they will be helpful as you look not only at the implications of the current proposed sale of GHA to Humana but also at the challenging larger issues of lessons to be drawn from the Group Health experience and implications for the future of health care services in the District under the President's forthcoming health care reform proposals.

As you know, I was one of three trustees who voted against asking Group Health members to approve a sale of GHA to Humana this summer. The members have given approval to such a sale.

I am a strong believe in health maintenance organizations of the kind that GHA pioneered. Group Health Association has set a model by providing for over 50 years quality, comprehensive, pre-paid service with an emphasis on prevention. Access to health care is

not an unfortunate accident to insure against but a service which all District residents should have available on a fair and affordable basis. As you know, the District does not classify or regulate HMO's as insurance providers. GHA's own articles of incorporation explicitly state that its purpose is to "arrange and provide... services" for its members and they don't mention "insurance.".

I regret the loss of member control and the introduction of the profit motive that will result from this sale. I also regret the conclusion reached in some quarters that the sale shows that "pure" HMO's cannot succeed in the marketplace or that only very large providers can be successful.

I think there are several lessons to be drawn from the GHA experience. They include:

1. Health care should not be linked to employment status.

2. Health maintenance organizations need to do a better job of communicating the advantages of pre-paid, comprehensive service.

3. Any health care system for the District under health care reform must be regional in nature, and

4. Complete community rating is a necessity.

Let me elaborate briefly on those points.

1. Health care decisions are increasingly made by employers and not by consumers. The health benefits officer at the company, who is deciding what plans or plans to offer to employees, becomes the client, and the needs and interests of the employer are not the same as those of the individual. Smaller health provider organizations like GHA can be particularly disadvantaged by this system. If health care was not linked at all with employment, consumers could make freer and better decisions.

2. The issue of "choice" in doctors in HMOs is also a red herring. The truth is that no one has a completely open choice of doctor, hospital, or other service, except perhaps a wealthy, totally self-financed consumer. All the plans, including the supposedly pure fee for service insurers like Blue Cross, make decisions about which providers will be in their plan and thus which providers the consumer can use. HMO's have been given a bad name in this matter, sometimes by their own fellow HMO's who are trying harder to compete than to promote the HMO concept. As a pure HMO, GHA was hurt by this marketing approach of its competitors. As a GHA member I always had a wide choice of primary care and other doctors. If HMO's are going to be part of health care reform for the District and the country-- and I think they definitely should be-- there will have to be a sincere and concentrated effort to tell their story better.

3. Health care providers serving the District of Columbia must be regional in nature. My experience with Group Health increases my concern that a strictly state by state system will put the District at a distinct disadvantage. One of the issues GHA struggled with was how to raise capital to open service locations in the faster growing suburbs beyond the Beltway. Approximately two thirds of the people who work in the District live in Maryland and Virginia, and as long as health insurance remains employment-linked, employers in the District will need access to health plans with service providers throughout the area. A strictly state-based system will also disadvantage the District because of its larger pool of lower income residents.

4. Community rating-- where everyone is charged the same amount for the same service-- is a necessity in order to fairly and fully serve the residents of the District. As a District government employee under FEHBP the combined monthly premium for my family (government and personal share) was slightly less than $300 a month as of December 1990. During the 18 month COBRA period, when I was able to stay on at the federal rate plus a small administrative fee, the monthly premium rose to only about $314. But the day the 18 months ran out and I was re-classified as a "direct pay" member the monthly premium rose by one-third to $414, and a few months later was increased again to $458. By the stroke of a statistical pen the same three adults, in the exact same state of health, went from one arbitrary grouping to another and paid 50% more for fewer benefits. There are large numbers of District residents who are self-employed or who work for small firms who are especially vulnerable because of the current rating systems. Maryland has recently enacted a community rating law which I understand is designed to eliminate this kind of discrimination.

What is ahead for the GHA legacy and tradition for residents of the District?

The GHA articles of incorporation provide that, "[up]on the dissolution of the corporation the Board of Trustees shall, after paying or making provision for the payment of all liabilities of the corporation, dispose of all the assets of the corporation exclusively for the purpose of the corporation in such manner, or to such organization or organizations organized and operated exclusively for the charitable, educational or scientific purpose as shall at the time qualify as an exempt organization or organizations under section 501(c)(3) of the Internal Revenue Code of 1954 or the corresponding provision of any future U.S. Internal Revenue law, as the Board determines." In accordance with this, members were promised that the sale to Humana would include "the establishment of the Association as a not-for-profit, charitable foundation to be the guardian of the proceeds of the sale". The Information Statement provided to members along with their ballot pointed out that "[since] Group Health is a not-for-profit, tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code, it is prohibited from distributing its assets and/or funds to any private individual or from using those funds to benefit private individuals. Your Board of Trustees, therefore, is recommending that you approve establishing a not-for-profit charitable foundation. As a charitable foundation, the successor to Group Health will no longer provide health care services to members, but will use the proceeds from the sale for scientific,

educational, and charitable purposes related to health care." [Information Statement, July 12, 1993, item II.D. at p. 6]

The exact nature of this not-for-profit successor to Group Health Association will depend to a large extent on the ultimate size of the net proceeds that are left after all the liabilities and contingencies have been worked out in the Humana sale. I intend for the Board committee that I chair to keep a sharp eye on the deal in order to protect as large an asset pool as possible for the successor non-profit. The committee's work plan also includes outreach and consultation with the Group Health leadership, members, and the larger community regarding the form and function of the successor non-profit. Among the suggested purposes are research, education, and services to vulnerable populations such as the elderly and teenage mothers. I would welcome the input of this committee as we go through that process.

This concludes my formal remarks this morning. I look forward to working with you and would be happy to answer any questions.

The CHAIRMAN. Dr. Lankford?

STATEMENT OF RONALD S. LANKFORD, M.D.

Dr. LANKFORD. Mr. Chairman, and members of the committee, my name is Ron Lankford. I am the senior vice president of medical affairs for Humana, one of the Nation's largest managed health care companies. We offer a wide range of affordable health plans and services to employee groups and Medicare beneficiaries. Humana health care plans currently cover approximately 1.7 million members, including over 250,000 Medicare beneficiaries and over 125,000 Federal employees.

As a company, our mission is to achieve an unequaled level of measurable quality and productivity in the delivery of health services that are responsive to the needs and values of health plan enrollees, physicians, employers and consumers.

I am pleased to be here today to testify on Humana's acquisition of Group Health Association. GHA has been serving the District of Columbia and the surrounding communities for over 50 years. We are excited to have the opportunity to work together with GHA to ensure the continued provision of quality health care for the District and surrounding communities.

GHA is a tradition in the DC area. It has a long, unmatched history of member, physician and employer involvement in the community. It has been a vital contributor to the DC economy as well as a key provider and insurer in the DC community.

We recognize the immense responsibility that the members of GHA have entrusted to Humana. Working from the foundations that GHA has established, it is our commitment to the members and to the community to provide the resources necessary to continue GHA's quality service in an increasingly competitive market environment.

The present market environment demands competitive premiums in a wide range of products and services. The challenges we face in turning this health care plan around are not unlike challenges we have faced in other communities. Witness our efforts in communities like Kansas City and Chicago. Our successes in these communities is rooted in our respect for the achievements of the health plans we acquired in those cities. Our know-how and capital investment have provided these communities with much needed upgrades in health centers, improved member services, and enhanced quality management programs.

We have enrolled HMO members in these federally qualified plans without underwriting, and we enroll more lower socioeconomic enrollees in each of those plans than are present in the market, and I can provide statistics later on request.

We have recently built two large clinical centers in Chicago, both located on the underserved South Side, and over 35 percent of the quarter million enrollees we have in our staff model operations are from minority populations.

Preserving GHA's best benchmark areas while bringing about the changes necessary to make it a viable competitor has been at the heart of our negotiations with the GHA health plan management. In this respect, Humana will strive to ensure continuity of

quality health care coverage. Humana will strive to maintain established physician-patient relationships. Humana will maintain member involvement and communication. Humana will preserve GHA's name. Humana will infuse capital that will allow the health plan to compete in today's competitive markets.

Last year alone, we infused over $20 million into the Kansas City staff model operation and over $8 million just recently in Chicago.

To meet these goals, Humana will continue to work closely with State and Federal regulators. More specifically, we support model NAIC legislation pending before the DC Council that will give the District oversight of local HMOs.

We are also committed to working with the District, Maryland and Virginia to explore innovative measures for assuring access to quality health care services for Medicaid and other medically underserved populations. Before we can do so, however, GHA's economic viability must be restored. We will reinvigorate GHA by introducing new health care coverage products, expanding the physician and hospital network, improving current facilities and adding new facilities.

In addition to its members, GHA's employees represent another constituent group that will benefit from Humana's acquisition. GHA has been steadily losing membership. If that trend continues, the employee base will continue to be decreased. Our intent is to reverse this trend and thereby preserve employment, and in the long run you can be assured that our intent is to grow the plan and the number of employees.

In conclusion, I appreciate the consideration afforded by the members of the DC Committee on having me here today. GHA's roots are deep in the District. It has long been a provider of quality health care services. However, GHA has struggled as competitive pressures on the health care market have increased. Humana offers GHA members the opportunity to retain what is best about the current plan while making the changes required to allow it to thrive in the future. GHA members have overwhelmingly endorsed this opportunity by returning a 90-percent positive vote for this transaction.

We at Humana are excited about the opportunity of providing health care services to residents of the District of Columbia and the surrounding communities, and working together, we feel we can achieve the successes we are all looking for during this transition.

Thank you.

[The prepared statement of Dr. Lankford follows:]

HEARING ON PROPOSED SALE OF GROUP HEALTH ASSOCIATION BEFORE THE COMMITTEE ON THE DISTRICT OF COLUMBIA

SEPTEMBER 14, 1993

TESTIMONY PRESENTED BY

RONALD S. LANKFORD, M.D.

SENIOR VICE PRESIDENT, MEDIAL AFFAIRS

HUMANA INC.

Introduction

Mr. Chairman and Members of the Committee.

My name is Ronald S. Lankford, M.D. I am Senior Vice President of Medical Affairs for Humana, one of the nation's largest managed health care companies. We offer a wide range of affordable health plans and services to employee groups and Medicare beneficiaries. Our Humana Health Care Plans currently cover approximately 1.7 million members including 262,300 Medicare beneficiaries and 128,000 federal employees.

As a company, our mission is to achieve an unequaled level of measurable quality and productivity in the delivery of health services that are responsive to the needs and values of patients, physicians, employers, and consumers.

Mr. Chairman, I am pleased to be here today to testify on Humana's acquisition of Group Health Association (GHA). GHA has been serving the District of Columbia and the surrounding communities for over 56 years. And, we are excited to have the opportunity to work together with GHA to ensure the continued provision of quality health care for the District and surrounding communities.

Humana GHA Transaction

It is fair to say that GHA is a tradition in the D.C. area. GHA has a long, unmatched history of member, physician, and employer involvement in this community. GHA has been a vital contributor to the D.C. economy as well as a key provider and insurer in the D.C. community.

We recognize the immense responsibility that the over 130,000 members of GHA have entrusted to Humana. And, working from the foundations that GHA has established, it is

our commitment to the members and to the community to provide the resources necessary to continue GHA's quality service in an increasingly competitive market environment-- a market environment that demands competitive premiums, a wide range of products and services, and a broad network of physicians and hospitals.

The challenges we face are not unlike challenges we have faced in other communities. Witness our efforts in communities like Kansas City and Chicago. Humana's success in these communities is rooted in our respect for the achievements of the health care plans we acquired in those cities. Our know-how and capital investment have provided these communities with much needed upgrades of health centers, improved member services, and enhancement of quality assurance programs.

In regard to the District, preserving GHA's quality service and protecting its membership while bringing about the changes necessary to make it a viable competitor in this area have been at the heart of our negotiations. In this respect Humana will strive to:

- ensure continuity of quality health coverage;
- maintain established physician-patient relationships;
- maintain member involvement and communication;
- retain GHA's name; and
- infuse capital that will allow us to compete in today's marketplace.

To meet these goals, Humana is and will continue to work closely with state and federal regulators. More specifically, Humana supports model NAIC legislation pending before the D.C. Council that will give the District oversight of local HMOs.

We are also committed to working with the District, Maryland, and Virginia to explore innovative measures for ensuring access to quality health care services for Medicaid and other medically underserved populations. Before we can do so, however, GHA's economic viability must be restored. We will accomplish this by:

- introducing new insurance products;
- expanding the physician and hospital networks that provide service to GHA members; and
- improving current facilities and adding new ones.

In addition to its members, GHA's employees represent another constituent group that will benefit from Humana's acquisition. GHA has been steadily losing membership. If that trend continues, GHA's employees and continued existence will be threatened. Our intent is to reverse this trend and thereby preserve employment in the near term while eventually growing the plan, and its number of employees in the long run.

Conclusion

In conclusion, I appreciate the opportunity afforded by Chairman Stark and the other members of the D.C. Committee to discuss our future partnership with GHA.

GHA's roots in the District are deep. It has long been a provider of quality health care services. However, GHA has struggled as competitive pressure in the health care market has increased. Humana offers GHA members the opportunity to retain what is best about their current plan while making the changes required to allow it to thrive in the future. Those members overwhelmingly endorsed this opportunity by returning a 90% positive vote for the transaction. We are excited about the opportunity of providing health care services to residents of the District of Columbia and surrounding communities. Working together with the community, we will achieve the success we are all looking for during this transition.

I'll be happy to answer any questions you might have.

The CHAIRMAN. Mr. Wool, I hate to interrupt you, but I am informed that I have 10 minutes left to make a vote, which I will do and return. So if you will bear with me for 10 minutes, we will have a brief recess. Excuse me.

[Recess.]

The CHAIRMAN. If our guests want to find seats again, we will resume.

Mr. Wool, as soon as we have reasonable calmness, so I can hear you and the clerk can hear you, we will ask you to proceed with your testimony.

Go ahead, sir. Thank you.

STATEMENT OF HAROLD WOOL

Mr. WOOL. I have been a member of Group Health for 54 years and for most of those years played an active role in its governance as an elected trustee and in other capacities.

I am here today, however, as chairman of the Group Health Member Rights Committee. This is an independent rank-and-file group of Group Health members organized last year to protect member interests when Group Health managers initiated a campaign designed to terminate Group Health as a not-for-profit membership institution.

First, I would like to express my appreciation, Mr. Chairman, for your holding this hearing and for giving us a chance to be heard. I have a prepared statement for inclusion in the committee's record. I would like to make several summary remarks from it at this time.

Group Health, as you know already, is a very unique health care institution. Not only is it the oldest plan of its type in the area, and perhaps in the country, but it also includes a very unique feature of consumer ownership and governance. It is the only plan in which the members of the board of trustees have been elected by its members.

Although chartered as a not-for-profit member corporation, it has functioned like a consumer cooperative, and consumers have had and expect to have a significant voice in major policy decisions affecting their plan. In fact, consumer participation over a period of years has made a difference in Group Health. We have worked over the years to expand the scope of services beyond the standard benefit packages offered by most plans in such areas as health education, broader preventive care, mental health and provision of hospice care for the terminally ill.

We have a unique arrangement under which a member who has a claim against the organization, a financial claim, and who is not satisfied with the initial findings of the administrators can appeal that decision to a claims' appeals committee consisting entirely of members. Above all, we have provided consumers with an added degree of assurance that all members will be treated fairly and humanely in the way their health care is administered, even at some cost to the bottom line.

A democratically run health plan like a democratically run nation can have its ups and downs. We have had some significant organizational problems over the years and some intermittent fi-

nancial crises, which Mr. Pfotenhauer touched on in his testimony. But until very recently, until 2 years ago, our enrollment did increase and it did increase at a greater rate, Mr. Chairman, than the rate of growth of the metropolitan area.

The allusion to decline in market share is a term of art which simply means that when Group Health got organized—and until the 1970s we had a 100 percent share of the HMO market because we were the only one in it—as the number of HMOs grew, as its definition changed to include, for example, the IPAs, there was an infusion of many other plans which commanded a greater share of the total market for health services in the area. Although we did not equally share in that, we more than held our own in relation to our total population, and the reference to a declining "market share" is, I think, very deceptive in terms of the status of the organization.

We have also had some financial problems. We had what turned out to be a temporary financial crisis about 2 years ago which was due in large part to the fact that a very large account payable due from HCFA—the Health Care Financing Administration—was being audited by that agency. This was not included as a current asset in the regulation assessment by the State of Virginia, and it created a situation of a crisis in which our measured assets as they counted them fell below their statutory requirement. This issue has since been resolved.

The amount involved I believe was in the neighborhood of $15 million, covering back payments for several years, and since then our financial reserves, by the admission of our officials, have been more than adequate. We have $11 million more in reserves than required by the State of Virginia under their definition and $17 million more than required in the State of Maryland.

The last years we have operated in the black, and this year, apart from some abnormal expenditures associated with a massive campaign fund to sell. I think we have a very good chance despite declining enrollment of ending in the black. What is even more important is that changes have already been initiated to make Group Health more competitive.

The representative of Humana referred to the offering of new products. We have already invested in a new "point of service" plan, which represents one of these new products, from our own capital and from our own resources.

Similarly, we are currently installing a brand-new management information system costing several million dollars from our own capital and our own resources, supplemented by commercial collateral loans readily available to us in the local financial market. The allegations of the imminent demise of Group Health because of its financial problems are far too premature.

I would like to emphasize that from our perspective what has happened in the last 2 years is that, prompted by what turned out to be at least a short- term financial crisis and what we hope will be a short-term enrollment decline, management saw an opportunity of seizing possession of Group Health. Together with its physicians, I think it began a concerted effort to eliminate the consumer role in Group Health, first by proposing last year a conversion to

for-profit status, which was defeated by the membership, and this year by the proposal for sale to Humana.

The way in which these wonderful votes were accumulated in the last referendum would, I think, warm the hearts of any remaining totalitarian dictators in the world planning the next plebiscite. Every rule of fair play in the game was violated in an organization whose bylaws say this is supposed to be a democratically run organization.

The very fact that a sale to Humana was being planned was kept a total secret until the day that the plebiscite began. All the sessions related to the review of alternative plans, which have been referred to, were held behind closed doors without any opportunity for member input outside of the board of trustees and management itself. The information needed to mount any significant opposition to the plan was simply not available until the ballots were already out.

In addition, an appropriation of $1 million has been made for a so-called restructuring fund, a major portion of which was devoted to a massive promotional campaign of a totally one-sided nature.

Now, in the vote approving the referendum, Betty Kane and two other members of the board voted against it, and I think their votes were based in large part on the issue of member rights. The fact that the members had not been informed; the fact that the details as to the plan had not been spelled out in a way which would permit an intelligent assessment of what might happen if Humana took over.

These still are not spelled out in writing, although we have had very glamorous descriptions of an oral type as to how wonderful the world would be. I hope it will be under Humana if that should transpire, but we have no concrete commitments on many of the most critical issues.

As a rank-and-file organization we are particularly concerned about some of our most vulnerable members, those who pay their own premiums and those who are members of small groups. As was noted, Mr. Chairman, in your statement, there are about 8,000 such members in Group Health, many of them already older. Many of them have acquired medical conditions and they are very fearful that—irrespective of the oral commitments of the new owners—their future coverage may be jeopardized.

For one thing, companies do drop nonprofitable units, and this has happened with hospitals of Humana and also some of their other plans. What protection would they have if in a few years time a decision should be made that a resale prove desirable?

Second, and I think even more important fundamentally, is that this proposal would effectively eliminate any meaningful consumer voice in the policies of our health plan. We have found that this voice has stood us up well in the past. It has assured us that basic protections we needed would be there and that we would be treated fairly. We are very concerned that we can't look forward to that under the proposed Humana sale.

We feel that this also has some implications for national policy. We feel that no matter how well-intentioned any governmental health reform plan may be, it cannot get into the kinds of issues which consumers on a day-to-day basis will be faced with in rela-

tion to their own health plan administration, and that retention of a meaningful consumer role in the health system is one of the safeguards which can protect us in this respect.

Thank you very much.

[The prepared statement of Mr. Wool follows:]

Statement of Harold Wool, Chairman
Group Health Member Rights Committee
at a hearing before the
Committee on the District of Columbia
U.S. House of Representatives
on the Proposed Sale of
Group Health Association to Humana, Inc.

September 14, 1993

Mr. Chairman and members of the Committee:

On behalf of thousands of rank-and-file members of Group Health Association, I want to express our appreciation to your Committee for holding this hearing on the proposed sale of Group Health Association to Humana.

In doing so, Mr. Chairman, I know that you have recognized that this proposal has important implications for the kind of health care that may be available to substantial numbers of residents of the Washington Metropolitan Area and also for related trends in the national health care industry.

GHA: A Unique Washington Area Institution

Group Health Association is unique in several respects:

● It is the oldest prepaid health plan of its type in the Washington Metropolitan Area and probably in the entire nation. Organized in 1937 by a few hundred employees of one small federal agency, it soon opened its enrollment to employees of all federal government agencies and, in the early post-World War II years, to all residents of the Washington area. Enrollments in GHA grew rapidly in the first three decades after world War II, from 9,000 in 1946 to 100,000 in 1975, helped by enactment of the Federal Employees Health Benefit plan in 1959, as well as by GHA's status as the only HMO in the Washington area until the early 1970s. Enrollments continued to grow in the ensuing 15 years, reaching a high of more than 150,000 in 1990 but have since decreased to 132,000.

● An important facet of GHA is the diverse economic and social background of its enrollees. Group Health includes among its enrollees substantial proportions of lower-income families, as well as those in the moderate and higher income brackets. Based on a member survey conducted in November 1990, about one-fourth of GHA families had an income of less than $25,000, about one-half reported incomes between $25,000 and $55,000, while the remaining fourth reported incomes higher than $55,000. Similarly, while one-third had an educational attainment of high school graduation or less, at the upper end, nearly one-fourth reported one or more years of post-college education. Racially, GHA has approximately similar proportions of blacks or other

minorities and of white enrollees. In short, GHA's members in many ways represent the metropolitan area population as a whole.

● Group Health Association is also unique in the Washington area in that it was created as a not-for-profit membership organization, governed by a member-elected board of trustees. And has always functioned in a manner similar to that of a consumer cooperative. In addition to electing the board of trustees, GHA members have a voice in major policy decisions affecting their health care through membership on board committees and advisory councils, and by participating in general membership meetings.

● Consumer participation has had a significant impact on GHA's health care program in many ways. In recent years, consumer members—working with staff—have promoted a number of significant programs including:

-- broader health education and increased preventive care,
-- improved mental health services,
-- improved geriatric services, and
-- initiation of hospice care for the terminally ill.

Consumer members were also responsible for establishment of a Special Assistance Fund, financed both by GHA and by member contributions, to help meet emergency medical needs of members for items not included in the GHA benefit package but which the member could not otherwise afford. GHA appropriations to this fund have averaged over $200,000 in recent years. We know of no other private health plan that has any similar fund.

● Although many younger, recent enrollees regard GHA as simply their health insurance plan, longer-term enrollees have established close links with their physicians and other providers and—with advancing age—have a much greater feeling of dependence on GHA as an institution. Among these older members are substantial numbers who are individually enrolled or are members of small groups. They feel particularly threatened by an ownership change that might endanger their continued coverage.

● Above all, as a member-governed health plan, we have provided consumers with a basic assurance that they will all be treated fairly and humanely in the way their health care is administered, even at some cost to the bottom line. Comprehensive and responsive health care has not just been another business for GHA, it is what we are all about. In any restructuring of the Association, as well as of our national health care system, we feel strongly that this priority must be preserved. Consumer participation provides an essential system of checks and balances that can assure than an HMO will not sacrifice fairness and quality care to the expediencies of profit. The proposal before us would eliminate this critical ingredient.

Raising the Specter of Financial Disaster

Management has misstated and purposely denigrated the financial position of GHA in order to scare members into supporting its proposals to change the status of the association to a for-profit organization under which they would no longer have a significant voice.

It has ignored the substantial improvement in the working capital position that has occurred since 1991. It has grossly overstated the need for outside sources of funds to meet essential requirements by ignoring the availability of internally generated funds which it own projections demonstrate will meet all of these requirements.

It has painted a picture of threatened intervention by insurance regulators despite the fact that its statutory net worth is almost $11 million greater than Virginia's minimum requirement and $17 million higher than Maryland's requirement.

And it has failed to disclose that it is implementing a turn-around plan, under which it has already taken steps to economize so as to assure that there will be no deterioration of its finances in 1993. Nor has it disclosed it will introduce new products and services in 1994 that, with a more competitive rating strategy, will permit it to resume membership growth.

The forgoing background facts are, I believe, relevant to your review of the current GHA/Humana sale proposal and of last year's attempt to convert GHA to a for-profit stock company.

The "For-Profit" Conversion Proposal

In March 1992, GHA management announced through the press that the Board of Trustees, after some six months of closed-door deliberations, had voted to immediately undertake the legal steps to convert GHA from a not-for-profit membership organization to a for-profit stock company, whose shares would be initially owned by management employees and physicians, in combination with unidentified outside investors, and a new not-for-profit foundation to be created for undefined charitable purposes. This action, it was reported, was taken on the advice of consultants of the investment banking firm of John Nuveen and Company as a means of raising an estimated $30 to $50 million of additional capital over the next five years for such purposes as building up its financial reserves and investments in new products and information systems.

In initial briefings of membership groups, GHA officers alleged that the trustees had the authority and were planning to proceed with this fundamental change *without any member approval.* As a direct reaction to these statements, a group of some 40 long-time members, including eight former trustees and other community leaders, organized the Group Health Member Rights Committee in April of 1992. Within a short period, hundreds of additional supporters joined this initial group. We retained counsel, Matthew S. Watson, who made it clear to Group Health trustees that under the District of Columbia law no conversion of this type

could take place without approval of two-thirds of the members at a meeting called for this purpose. [29 D.C. Code, §547.]

One immediate result was that the Board of Trustees was compelled to schedule not one, but two, referenda on this issue. The first, held in July, provided for amendments of GHA bylaws to allow member approval of conversion or sale of GHA by a mail ballot. On advice of counsel, the Member Rights Committee did not take a position on this proposal because there was substantial doubt as to it legality. The second referendum in September would have given the Board of Trustees a blanket authority to dispose of assets of GHA as it saw fit.

The latter proposal was vigorously opposed by our Committee on several grounds:

1. The trustees were asking for a "blank check" without providing any specifics about who the new outside owners would be, how member health benefits or coverage would be affected, or other terms of the sale.
2. Experience in similar for-profit takeovers, particularly in California, had shown that insider groups, such as management and doctors, had reaped large profits while members had experienced less satisfactory service.

3. Finally, we were convinced that, despite recent enrollment declines, GHA's financial condition was still sound, and that with proper leadership, the needed management improvements and cost reductions to improve GHA's competitive position could be accomplished as well or better while remaining a member association.

In undertaking this campaign we recognized we were fighting against great odds. The Board of Trustees had reneged on earlier commitments to include statements of opposing points of view in its mailings to the members. This was contrary to the democratic principles to which GHA is committed and its traditional practice of presenting pro and con positions on controversial proposals.

Instead, management initiated a massive one-sided propaganda barrage, including three first-class mailings, two Washington Post ads, and all the other trappings of a costly political campaign. With our limited resources, consisting entirely of contributions from supporters, the Member Rights Committee was compelled to rely mainly on distribution of leaflets to those members attending GHA clinics during the referendum period. These leaflets were distributed by volunteers standing outside the clinic buildings, since management had denied them access to the building lobbies or waiting rooms. With these handicaps, we could convey our message to only a fraction of eligible GHA voters.

Yet, in the face of these odds, the Member Rights Committee succeeded in defeating this referendum. About 40% of those voting cast a "no" ballot, substantially more than the one-third vote needed to defeat the proposal. It is clear that with a level playing field an overwhelming majority would have rejected the proposal.

The Proposal to Sell to Humana

After the failure of the conversion proposal, the Member Rights Committee proposed that there be discussions with interested member groups on how to proceed in the common goal of maintaining Group Health Association as a viable, thriving part of the health care system in the metropolitan area. Management rejected this proposal and proceeded behind closed doors to consider a sale proposal while completely excluding member input.

Without seeking any other advice, management again called upon John Nuveen and Company, which previously recommended the discredited proposal. Management now sought to accomplish, without any member involvement, its goals by planning to selling Group Health Association in its entirety instead of retaining its independent identity.

Management also determined that it would gain approval at any cost. First, it kept its plans secret so as to prevent dissenting views from any member or group of members. Second, it planned to schedule the voting during the middle of summer which would be the most difficult time for opponents to mount a campaign. Third, management had available to it a budget of $1 million of funds paid by members for their health care that it could use to frighten members into believing that they would lose their health coverage if the Humana sale proposal was not approved.

Management was successful in keeping its plans secret. A letter of intent to sell Group Health to Humana was negotiated without knowledge of the members. No notice was given of the negotiations until the vote was scheduled and ballots were actually in the mail on July 12. Thus management succeeded in presenting its own views to the members before any member who might disagree even had knowledge of the proposal or a chance to respond.

It is clear that management had no intent to make a fair presentation to members. The approval of the proposal by the board of trustees was not unanimous. Three trustees, all elected earlier this year, voted against approving the letter of intent. The dissenting trustees requested that their position be transmitted to members along with the official information statement. This request, upon the advice of management and its counsel, was denied. Members were thus intentionally deprived of even this knowledge, a procedure that can only be described as not meeting any minimum standard of fairness.

It is not surprising that the outcome of voting favored the management proposal. The combination of secrecy and impediments to presentation of dissenting views was quickly followed by a systematic telemarketing campaign urging members (ironically, with their own money) to quickly vote. Within two weeks, half of the ballots had already been returned—before these members had the opportunity to hear any opposing views.

While it was denying dissident trustees the opportunity to make their views known and obstructing the ability of the Member Rights Committee in its use of membership mailing lists to communicate with members on a timely basis, GHA management was simultaneously

bombarding members with pro-sale information. No less than four mailings were made to members and a telemarketing firm was retained to call each member on behalf of the management proposal. Particularly upsetting to the Member Rights Committee is that GHA mixed medicine and politics by pressuring physicians to approve GHA mailings of letters to their patients over their signatures in support of the sell-out proposal. We believe this to be a violation of medical ethics.

These letters—prepared by management, sent on GHA letterhead, and mailed at members' expense—masqueraded as the unsolicited opinions of the individual physicians. The doctor-patient relationship should not be abused in this way. More troubling is that the letters were signed by doctors who have a direct personal financial interest in the outcome and who did not disclose that interest. Humana has promised that, if the sale is consummated, it will contract with a profit-making corporation—owned exclusively by the physicians—to provide medical services for Group Health. This direct personal interest was not discussed, nor did the information statement in any way discuss potential conflicts of interest on the part of management or its financial consultants.

It is worth noting that for-profit corporations are required by law to make a balanced statement of the issues placed before stockholders. Surely members of a nonprofit membership-owned and -governed corporation are entitled to at least as much.

The voting in this election can only be described as rigged and no fair-minded person can be surprised that management succeeded in its campaign.

Not only does the Member Rights Committee believe the conduct of the election was unethical, we believe it violated District of Columbia law. Suit has been filed in District of Columbia court to invalidate the results based on the improprieties discussed here today and on specific violation of the meeting procedures required by District of Columbia law for any such sale. We expect to be successful in court. (A copy of the Superior Court complaint can be provided for the record should the Committee desire.)

I want to close by restating our belief that the maintenance of an informed and significant consumer voice is an important ingredient in any health-care system. Consumer participation can assure that human needs are considered to at least the same degree as financial needs. And, for these same reasons, a member-governed plan such as GHA will be far better motivated to assist in meeting the needs of the many hundreds of thousands of medically uninsured or under-insured in this area, as is being contemplated in major proprosals now under consideration.

Again, I appreciate this opportunity to testify to this committee and would be happy to respond to any questions or to submit additional information that might be helpful in your consideration of what we believe are important issues.

The CHAIRMAN. Thank you. The Chair must say that he's perplexed about the whole situation. I would say to Ms. Kane and Mr. Wool that I have a hunch that you all are paddling upstream. The captain has left the ship along with the crew and left the passengers.

You are quite right. If the captain tells you that the ship is going to sink and then he opens the shuttlecocks and takes lifeboats and runs away, I am afraid that even if you won it would be a rather pyrrhic victory. I just don't know.

I would admit that with the campaign that was run, probably President Clinton would like to get a hold of the manager so he could run a similar campaign for his own health care plan, which is equally as vague as the one that is being suggested to the members.

We have a bunch of bumper stickers they are passing out already for the President. I am going to see if I can sell some of them to GHA or Humana. They are interchangeable.

So I don't know what to ask you, and I am really not sure what to ask Humana. I do not intend to make this a referendum on their efficacy or ethics, nor the present management.

There are some concerns that come to mind both for the members of GHA and also about how this whole operation might work if something similar to what the President proposes comes into being. I don't suspect that it is the province of the District Committee to get between you and the regulation of the District of Columbia. It certainly is not my intention to do that. But there are some things that we might learn from this.

I think the easiest position to understand, and I will come to some direct questions in a moment, is Humana's. I can't believe that Humana wants to buy into a union contract. I would think they would avoid that like the AIDS epidemic. There is some indication that they don't intend to deal with that anymore.

But it is a big fish, and getting an HMO started is an expensive proposition. So what value they are acquiring from GHA as near as I can tell rests solely in the subscription list, in the beneficiaries. It gives them a book of business from which to get a foothold in a market, and I see nothing illegitimate or unethical or immoral about that. It might be that the GHA community, particularly those with preexisting conditions, may have some problems that the District might want to deal with in legislation that would prohibit those people being disenrolled.

Humana has a detailed record of high disenrollment when they come into a community and take over. I am not sure I have any statistics of which people are disenrolled most rapidly, but I could guess. So that could be a problem.

What happens to the group of physicians, I guess I am less concerned about, although they may be perfectly nice people. They are easily employable at salaries far higher than the average of anybody in this community, and I am sure that if they are good, they will find homes and employment in a meaningful way. So I don't know that there is any public interest there. But I guess there is some concern.

Mr. Pfotenhauer, GHA has started a physician's professional corporation called the Mitchell Trotman Medical something PC; is that correct?

Mr. PFOTENHAUER. We have encouraged physician leadership of the organization to form their own professional corporation. The board has been supportive of that.

The CHAIRMAN. How long ago did you start that?

Mr. PFOTENHAUER. That corporation was incorporated in the Commonwealth of Virginia, I believe, within the last probably 3 to 4 months. It was not incorporated by GHA. It is a separate——

The CHAIRMAN. Yes. But what led you to encourage it or foment it? Is that at the suggestion of Humana?

Mr. PFOTENHAUER. No. It really is part and parcel of the analysis that has been going on for over 3 years. There was a high level of consensus between the medical leadership, the board leadership and management that the current structure of the entity in which we had a unionized group of physicians who through their contract assumed no risk, no business risk, for the overall entity, in the long term reflected a very low probability of success, and that the heart of any restructuring for future success was the requirement that physicians form a medical group and contract at arm's length with the entity.

The CHAIRMAN. Did you have in the concept of this PC a risk contract for the physicians?

Mr. PFOTENHAUER. That they would share in the risk of the overall entity.

The CHAIRMAN. Was there a 20 percent withhold? What kind of a risk arrangement did you have with them?

Mr. PFOTENHAUER. That was a detail that went far beyond the overall conceptual framework.

The CHAIRMAN. So there is no existing risk contract in this PC?

Mr. PFOTENHAUER. Not at the present time. It is an embryonic corporation.

The CHAIRMAN. I have also heard that you are asking them, the physicians, for a $25,000 capital contribution to join.

Mr. PFOTENHAUER. Mr. Chairman, to clarify again, I am not asking the physicians for a $25,000 contribution. I am not part of that corporation. It has been incorporated by Dr. Donald Mitchell and Dr. Charles Trotman, who are physicians who have been employed by Group Health in the past. Their intent is to make this vehicle available to physicians who are currently employed by Group Health.

Management of Group Health has no interest, no involvement directly with the PC at this time.

The CHAIRMAN. It has no contract with them?

Mr. PFOTENHAUER. We do not have a contract with them.

The CHAIRMAN. Have you got any contact with them, Dr. Lankford?

Dr. LANKFORD. Yes. We have met with them a number of times to discuss the issues and the formation, and the questions they may have.

The CHAIRMAN. Have you suggested various kinds of risk contracts that you would want them to enter into?

Dr. LANKFORD. We have talked to them preliminarily, not about number, but about organization and the number of physicians that may be needed given the enrollment, and access issues, where we have concerns in terms of access.

The CHAIRMAN. Would they be the sole providers as you envision this new operation? Would you contract with them on a capitated basis?

Dr. LANKFORD. We don't envision that they will be the only provider.

The CHAIRMAN. Would they be dealing with you on a capitated basis?

Dr. LANKFORD. We will be providing them with a monthly capitation rate.

The CHAIRMAN. Would there be any risk-sharing in that?

Dr. LANKFORD. We have limited their downside risk so that their downside risk is minimal but allows for some upside potential.

The CHAIRMAN. When you say minimal, 20 percent roughly?

Dr. LANKFORD. The final numbers haven't been finalized, but it will be small.

The CHAIRMAN. Was this something that you generated? I mean something you felt you wanted to move into and for continuity, to keep the plan operating on the assumption that your purchase goes through? Was that the reason for this PC to operate?

Dr. LANKFORD. Well, there are many issues that the physicians have to face in terms of getting their house in order, and it is our opinion that it is best done behind closed doors by those physicians.

We will provide numbers, expected staffing ratios, and standards for access, but their own corporation will have to figure out how to provide those to the degree they can. When they show us that they can't do that, then we will be responsible for figuring out what to do to make sure access is there.

The CHAIRMAN. This $25,000 capital contribution, is that in play? Is that being discussed at this time?

Dr. LANKFORD. That is not part of Humana or GHA. It is simply that the physicians involved think it makes sense.

The CHAIRMAN. If this is not competitive, do you intend to? Don't you have a Medicare risk contract? I am not even sure whether GHA has one now.

Mr. PFOTENHAUER. We have a cost contract.

The CHAIRMAN. Cost contract. What do you intend, Doctor? Do you know?

Dr. LANKFORD. Well, certainly we have a great deal of Medicare risk experience throughout the country. It has been our experience that the medical system and the health plan has to be running smoothly, have capacity, and have all the medical delivery side issues under control before the introduction of anything as complex as Medicare risk. We would certainly love to see that happen at some time in the future.

The CHAIRMAN. Do you have any intention to bid on Medicaid contracts with the District?

Dr. LANKFORD. We have had preliminary discussions with individuals in Maryland and Virginia, looking at possibilities, and we will continue those. But they are very preliminary at this point.

The CHAIRMAN. In expanding your market, would it be Humana's intention to compensate its sales agents on a commission basis?

Dr. LANKFORD. I can't speak to marketing. It is really an area I don't manage, so I will have to defer.

The CHAIRMAN. Could you find the answer for us?

Dr. LANKFORD. Sure.

[The information follows:]

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Ronald S. Lankford, M.D.
Senior Vice President of Medical Affairs

bcc Heidi Margulis
FILE DC Cmte
Hearing (Stark)

H. MARGULIS
NOV - 2 1993
RECEIVED

November 1, 1993

Humana

The Honorable Pete Stark
United States House of Representatives
Committee on the District of Columbia
Room 1309 Longworth House Office Building
Washington, DC 20515

Dear Mr. Chairman:

I am writing to follow up your request for information regarding Humana's plans for compensating sales agents in the Washington, D.C., area.

Before Humana decides how to compensate the Medicare sales agents, we will survey the market practices of competitors to establish how others compensate salespersons. Based on those results, a decision on how to compensate salespeople will be made. In order to avoid any possibility of unethical sales practices by Humana Medicare sales agents, Humana has implemented sales policies in each of its markets which provide for thorough and ongoing training and monitoring of sales agents.

Once again, Humana is excited to have the opportunity to work together with GHA to ensure the continued provision of quality health care for the District and surrounding communities.

Sincerely,

Ronald S. Lankford, M.D.
Senior Vice President

prp

Post-it™ brand fax transmittal memo 7671	# of pages ▸ 1
To Linda	From Patti Sannen
Co. DC Committee	Co. Humana
Dept.	Phone #
Fax # (202) 225-2009	Fax # (202) 429-9594

The CHAIRMAN. You might know—the Members of Congress didn't know. But it becomes apparent that the administration would like us to operate through alliances, and it becomes equally clear that whoever is a successor to GHA will be in three different alliances and have three different premiums. That is an interesting phenomenon. Your members will have to belong to a plan through an alliance in the jurisdiction in which they live, and I gather you operate in Maryland, Virginia and the District.

So are you making any plans to divide this operation into three—like Caesar?

Dr. LANKFORD. I know that the marketing and planning areas of the health plan have looked at this in detail, and since the final plan is still not out and in cement, I believe they have done preliminary looking at it but don't know further than that.

The CHAIRMAN. I don't know whether you have thought about it, either Mr. Pfotenhauer or you, Dr. Langford. On the assumption that if Congress were to pass the President's proposal, and that we were to contain costs by setting premiums above which you could not charge, how would you adjust your operation? Let's say the premium were set lower than what you feel you had to charge. What would you do? You are giving them a fixed set of benefits. What room does that leave for you?

Dr. LANKFORD. There are really only three variables in the business. If it is a staff model operation, you try to improve efficiencies and productivity. On the purchase of service side, you look at the rate of utilization of services and see if they are appropriate and are associated with some positive outcome. Last, the cost that you pay for individual items, the rates, the purchasing agreements that you can do.

We hope to be able to work with GHA to allow them to piggyback on some of our purchasing agreements for economies of scale and to help them any way we can on those issues.

The CHAIRMAN. But there isn't really much room, is there, in modern medicine? The physicians, if you have an IPA model, will receive a fixed fee, which will be set by some yet-to-be-determined group. If you are in a staff model, that is up to you to set it by salary. But it has always been a puzzlement to me, where we are going to control cost by limiting the revenue we give you, when your option really isn't to reduce services not necessarily to reduce the standard of health care but perhaps have longer waiting lines, perhaps have tougher gate keeping, a whole host of things. I don't know how else you can bargain.

Mr. Pfotenhauer, how would you do it? Let's say you were still running GHA.

Mr. PFOTENHAUER. Well, I think that first of all you start with the assumption, and I again find myself, perhaps, in the odd position of agreeing with some of Mr. Brand's earlier testimony. I think I start with the assumption that the fee-for-service indemnity health care system that still is predominant in the country today has a gross amount of waste and over utilization that needs to be curtailed. So clearly the utilization and management techniques that have been discussed here briefly this morning are the cornerstone of quality health care organizations that are in the managed care business.

I think under health reform, the reality is that as a society we will undoubtedly undergo some significant changes in how we value health care professionals and at what income levels they should be compensated in the future. That will clearly be one of the outcomes.

The CHAIRMAN. I take it your next job is not as an associate of the American Medical Association.

Mr. PFOTENHAUER. That would probably be a safe assumption.

But basically, I think HMOs, managed care entities under health reform will continue the quality improvement practices that they have begun to utilize over the last several years to try to make sure that there is continuity of care as well as appropriate care, which does not always necessarily mean doing another test or another procedure. So I think significant savings can come from that side of the equation.

The CHAIRMAN. I want to go back, if I may, with Humana on Medicaid, and Mr. Pfotenhauer. I am going to guess that in the District of Columbia, just in very round figures, that we have 600,000 people, 300,000 of whom are insured, probably half in Medicare, a third of that 300,000—100,000—in Medicare, and 200,000 Federal-State employees, and maybe a few private.

I am told 110,000 in Medicaid, 80,000 in Medicare, and private of 152,000, uninsured of 132,000 although I am informed that the Medicaid population is probably another 40,000 out there who qualify who just don't get the paperwork done.

So we are talking about 240,000 or 250,000 people either in a Medicaid system which has poor access to a large degree or the uninsured who have the equally poor access but no coverage.

How many of those 240,000 people would you suspect that Humana would have the capability, after investing this $40 million, to bid to serve?

Dr. LANKFORD. Well, as I mentioned before, not just in the Mid-Atlantic, but we are working in Florida to become involved with their Medicaid project. We are also working with the State of Texas on their project, and as it turns out, unfortunately, each State likes to reinvent the wheel as to eligibility and reimbursement and benefits.

So I can only say today that we are very interested in the three areas out here. But we will be meeting with the District officials and the two States' officials as to how exactly they are going to run their program, what is covered, what the eligibility issues are involved in Medicaid, and make our decision at that point.

We have not done a full analysis, as far as I know, of the geography and demographics of what we would have to do to be involved.

The CHAIRMAN. What would you guess? You are buying into what, a hundred and how many thousand members, Mr. Pfotenhauer?

Mr. PFOTENHAUER. One hundred thirty-two thousand.

The CHAIRMAN. A hundred thirty-two thousand. Have you got room now for another 20,000-30,000 members?

Dr. LANKFORD. We could add with the current facilities a few more members. A number of our centers are fairly full, but there is some additional capacity.

The CHAIRMAN. Some is 5,000; 10,000?

Dr. LANKFORD. Probably in the 20,000 to 25,000 range.

The CHAIRMAN. Doctor, we have had previous people here. I don't mean to load this question. Such socially conscious companies as Prudential have been quite straightforward in suggesting that they would not bid on a contract in the District of Columbia, because the District in its wisdom has a rule that if you have a Medicaid beneficiary in your plan, all of your providers must be accessible to that Medicaid beneficiary, and Pru has felt that many of their providers would not like that and therefore they chose not to bid.

Would that trouble Humana? Do you normally make all of your providers in an area accessible to the Medicaid beneficiaries in your plan?

Dr. LANKFORD. Well, where we do Medicare and commercial all of our providers, in essence, go on both product lines.

The CHAIRMAN. Medicaid?

Dr. LANKFORD. With Medicaid, as I just mentioned, we are just starting into those projects and I don't know. Obviously, it would be less of a problem in a staff model than it would if you had 500 contracts with private doctors. But again, we would have to sit down with the membership and the physicians and see where we are.

The CHAIRMAN. It is not your intention to run a staff model operation here in the District, is that correct?

Dr. LANKFORD. We will be running a group model for sure, and we will augment that as necessary to handle different products and more capacity.

The CHAIRMAN. Just let me ask you hypothetically, both of you, as experts in operating group plans and HMOs and preferred provider—let's just say 100,000 Medicaid and uninsured for a variety of reasons—if, Mr. Lankford, you are not familiar with the demographics I am sure Mr. Pfotenhauer could summarize those in his answer.

Would you go in and could you go in, with your current operation, and service 50,000 people in wards 7 and 8 and provide the same level of facilities and the same premiums that you might provide in Chevy Chase?

Mr. PFOTENHAUER. Well, at the present time we do not have a facility in ward 7 or 8. We have facilities——

The CHAIRMAN. Nor does anybody else.

Mr. PFOTENHAUER. We have one, though, very close in Marlowe Heights, right across the State line. We have a number of members in wards 7 and 8, however. Fifty thousand would be a tremendous stretch, in a short period of time.

The CHAIRMAN. You have about a couple hundred thousand that we have to find a home for.

Mr. PFOTENHAUER. Right. Correct.

The CHAIRMAN. I do not pick that 50,000 out of the air just to stagger your imagination. I am serious as to where we are going to find——

Mr. PFOTENHAUER. I think it is a serious issue. I think that clearly theoretically, the issue would be tied to how quickly Humana would convert the plan to a mixed model of a group network

model, how many additional private physicians would become part of that network, could serve large portions of that population.

Fifty thousand would be a real stretch, certainly, with the current service capacity of the Group Health medical centers.

The CHAIRMAN. Yes. In your study you showed that you were going to grow by 50,000 from 1993 to 1995. Where did you anticipate you were going to sign those folks up?

Mr. PFOTENHAUER. I am unclear on what study this is.

The CHAIRMAN. Group Health Association, Incorporated, Capital Needs, and you have average participants here and it says: 1993, 136,000; 1994, 145,000; 1995, 180,000. With a little windage you could squeeze 50,000. You could say you were trying to get 50,000 more people in there. I was just wondering where you thought those participants, geographically speaking, might come from.

Mr. PFOTENHAUER. Mr. Chairman, perhaps you do not have the backup for that study. It assumed that we would be developing additional medical center sites in each of those years in order to handle that additional growth, and that was a good portion of the capital needs was to develop new sites.

The CHAIRMAN. Where were you going to develop those?

Mr. PFOTENHAUER. It was envisioned that we needed to move farther out, outside the Beltway. Clearly, one of our competitive disadvantages is that as the cost of houses has escalated in the District of Columbia, a large number of younger families are moving farther out.

We have really only one facility that is outside the Beltway at the present time. Our facilities within the District, really, are four locations in the west end. So primarily we were looking at expanding farther into the suburbs.

The CHAIRMAN. With your current premiums, do you have a single rate, an age rate? I don't know how you charge for your current plan.

Mr. PFOTENHAUER. We use community rating for a large number of groups. For the largest groups——

The CHAIRMAN. Give me an average individual and family rate. Can you?

Mr. PFOTENHAUER. At the present time the premium for a single is probably in the $160 range, and a family could range from $325 to $380.

The CHAIRMAN. Three what?

Mr. PFOTENHAUER. $375 to $400.

The CHAIRMAN. So $4,800 on a family plan and $1,920 for a single?

Mr. PFOTENHAUER. $160, I said.

The CHAIRMAN. Per year. I am trying to do this by 12 with my shoes and socks on.

Mr. PFOTENHAUER. Okay.

The CHAIRMAN. $2,000 to $4,500, around in that. Okay.

How does that compare with your rates in any comparable market, doctor?

Dr. LANKFORD. Well, you have to look at comparable markets really by the cost-of-living within markets.

The CHAIRMAN. Well, then give me your high and your low in the country.

Dr. LANKFORD. If we say that this is a high market like Miami, those rates are slightly higher than we charge in Miami.

The CHAIRMAN. Do you have higher rates anyplace in the country than those for singles?

Dr. LANKFORD. These?

The CHAIRMAN. Yes.

Dr. LANKFORD. No, not that I am aware of.

The CHAIRMAN. Significantly lower anywhere?

Dr. LANKFORD. Well, sure. Chattanooga, Tennessee.

The CHAIRMAN. What do they run there?

Dr. LANKFORD. Rural areas can be a lot less expensive. Just like the AAPCs, you can have much lower rates in different places.

The CHAIRMAN. Do those rates seem reasonable to you?

Dr. LANKFORD. We think they are not competitive today. We think we have to bring those rates down to be competitive.

The CHAIRMAN. That is competitive, I gather, to group purchasers. Is it fair to assume that individual purchasers are not as rate sensitive as group?

Dr. LANKFORD. I don't know. Certainly the group purchasers are. Certainly rates that high lead a lot to why we have had rapid drops in enrollment.

The CHAIRMAN. I would just note for the record that the Chair has several other questions here to direct to Humana which deal with the Michael Reese operation in Chicago and the recent charges against George Atkins and others. But I don't know as that serves any useful purpose in this particular dialogue. I don't know what I would learn from it.

You had indicated, Ms. Kane—I think it was you, or perhaps it was Mr. Wool—that you had talked about trying to organize again out of the ashes, to see whether you could get another group going. Is that something that either or both of you are still considering?

Ms. KANE. Let me clarify it. I think I did mention that. The articles of incorporation of Group Health itself require that upon dissolution of the organization that the proceeds or the net assets have to be given toa 501(c)(3) nonprofit for educational, scientific, or charitable purposes. Group Health is a 501(c)(3) organization.

I will not speak for the board. I can tell you that it is a fact that the board is following a process to decide what the nature and function of what we call the successor nonprofit will be.

The CHAIRMAN. How much money do you think will be left on the table when all this is done? Is there a range? I remember hearing that discussed in the past.

Ms. KANE. Well, I can tell you without violating any confidence, I believe, what the numbers were that were presented in the public information given to the members, and that was—I have it here—net proceeds of the sale, the cash portion of the purchase, approximately $26 million to $31 million reduced by certain liabilities not assumed by Humana. There was a pension liability of $12 million mentioned in this information. That is the process that is still ongoing.

The CHAIRMAN. So you are talking in the neighborhood of $10–$12 million that would be available as a charitable residual?

Ms. KANE. It could be.

The CHAIRMAN. Are there any plans for the use of those funds at this point?

Ms. KANE. Well, there is a working group of the board which I am chairman of that is working to, first of all, look at what the IRS rules are, and the other provisions, that would govern some of how to use the money. We have started a consulting process with the other leadership in Group Health and with the members and with the larger health care community in the District and the region to gather advice on what the most appropriate use of that money would be, and also to talk with experts who have run other foundations, other organizations, as to what the practicalities of that are. Until the sale is concluded and there is an actual dollar amount that we are working with, that can shape in many ways what this organization could do.

The CHAIRMAN. It is a matter of indifference, Dr. Lankford, to Humana what they do with that?

Dr. LANKFORD. No, although just from past experiences, these can become very positive community organizations.

The CHAIRMAN. One would hope so, yes. But I mean you don't much care. That's out of your realm.

Dr. LANKFORD. That is right.

The CHAIRMAN. You want to go and run a medical plan. Okay.

Mr. Pfotenhauer, as far as you are concerned, that becomes a successor corporation or board to the existing operation of a medical plan, and the current management is not——

Mr. PFOTENHAUER. I don't see myself becoming executive director of the foundation. I am not sure they would ask me to serve that role. But that's never been part of my career aspirations.

The CHAIRMAN. Well, you know, there is, I suppose, a silver lining to everything, Mr. Wool. Ten million dollars, give or take a few, is not chump change.

Mr. WOOL. Mr. Chairman, may I say something?

The CHAIRMAN. Ms. Kane, did you want to elaborate on that further?

Ms. KANE. I did just want to add, speaking again as an individual here, that I certainly don't intend for this foundation or whatever successor nonprofit to relieve Humana of whatever corporate responsibility it will have as a corporate citizen in terms of charitable and other kinds of good works for the city.

The CHAIRMAN. Speaking of that, what is the obligation of Humana in this operation to those people who have a permanent preexisting condition? Let's assume that among your membership you have diabetics or people with AIDS or people with chronic hypertension and there is not any other insurance company that is going to take them.

What kinds of assurances are there that these people will receive continued coverage and care at a reasonable price?

Dr. LANKFORD. Well, remember we are dealing here with a qualified HMO and underwriting is not spelled out in HMOs, so people that are enrolled are enrolled when they come into——

The CHAIRMAN. Now don't push me to deal with Humana's experience in changes in enrollment after you have acquired other plans that has been documented in Florida and Chicago and other areas. We could return to Mr. Brand and others who understand

the subtle methods in which enrollment can change through encouragement, so I guess I would want to put that more in the affirmative.

What kinds of plans has Humana made to identify those members—or Mr. Pfotenhauer, perhaps you can quantify it—of the plan who would be unable to find insurance in the current market for any reason—convenience of location, cost of the premium, et cetera—if they were unable or it was almost impractical, if not impossible, for them to continue in the new plan? Is there any kind of assurance that——

Mr. PFOTENHAUER. Mr. Chairman, I am glad you raised that because that really is at the heart of the sale proposition from the standpoint of the elected board of trustees. When the board began contemplating sale and went out through a confidential memorandum to 12 parties, many of them nonprofit, not all for-profit, it was made clear that a deal breaker was the response that they would make, dealing with what we define as the most vulnerable members; namely, three categories as it evolved—direct pay members, a number of them in their 40s and 50s who have paid, written a check out of their own checkbook for a number of years and are in fact now diabetic, a number of them with chronic conditions, preexisting conditions that if they were dropped after sale would find it very difficult to be picked up by anyone.

There are also, I believe, about 200 groups within the District, small employers, where we are the only health insurance provider to that employer. The District, unfortunately, at the present time from a public policy standpoint has no conversion option for individual employees, If the employer, the barber shops or the beauty shops, drops the insurance, in Maryland and Virginia those individuals could roll over to a personal plan. They would pay their own premiums, of course, but they would have the right to coverage.

The CHAIRMAN. What about the COBRA provisions? That I think would carry them for 18 months.

Mr. PFOTENHAUER. Eighteen months. But beyond that, as I understand it, they would not have that protection.

Humana—it is part of the definitive sales agreement, and it certainly was in the letter of intent that was discussed in detail in the information statement—has made a lifetime commitment to the direct pay and personal plan people. As long as people pay their premiums, of course, they will have continuous coverage.

The people in the small groups in the District will be given, I believe, the conversion option that is currently afforded people in the State of Maryland. So that becomes a very critical part of it.

I might add that some of the other organizations that we had discussions with were, frankly, not prepared to take that step and removed themselves or we decided that it was not appropriate to continue the discussion.

The CHAIRMAN. That is reassuring. I am pleased to hear that and you are to be commended.

Let me just as an aside ask Dr. Lankford and Mr. Pfotenhauer—I can't resist, having these experts here; I just can't resist—Have either of you or are either of you aware of any prospective risk adjustment plan to which you would stake your professional careers

as being able to resolve any differences in risk in a flat-rate or community-rated system? Do you know of any?

A risk adjustment plan, doctor, would be one where you are going to have community rating, let's say. But the intention is that if your plan for some reason that can be determined through statistical analysis has a higher risk, you will adjust that risk.

Now that's a very good idea, one that insurance companies would all subscribe to. There is a problem. The plan doesn't exist. As near as we know, from the search of every Ph.D dissertation in the last hundred years, and in any prospective sorts of things you could do a little age and a little gender, but beyond that they have been unable to get within 20 percent of it. I just wondered if either of you have heard of any program or analysis that would make you feel that you would like to risk your own operation.

Dr. LANKFORD. I am not aware of a prospective system that can do that.

The CHAIRMAN. Mr. Pfotenhauer?

Mr. PFOTENHAUER. No, not even close.

The CHAIRMAN. Nor am I, and I just like to ask the experts all the time.

Ms. Kane, you were about to indicate—I couldn't tell which way you were nodding, but while we were talking about this assumption of the vulnerable population; is that something you are comfortable with in terms of the agreement as a board member?

Ms. KANE. Certainly in terms of my own personal vote on the sale, and the members have approved the sale, the board will vote on it—that's not taking a vote, obviously, on the final deal—it is certainly an issue that I will want to look at the words on and how ironclad the guarantees, and it is certainly a major criteria for me. Yes.

The CHAIRMAN. Mr. Wool, what——

Mr. WOOL. First of all, I would like to——

The CHAIRMAN. Let me ask you this, Mr. Wool.

Mr. WOOL. Sure.

The CHAIRMAN. Maybe you know the answer. The contention that has been made here today is that GHA was on the skids, going down the chute, without Humana. But if Humana had not come along on their white horse, how would you as trustees have guaranteed these at-risk vulnerable enrollees continued coverage? What would you have done?

Mr. WOOL. Well, are you talking about if Group Health continues without a sale?

The CHAIRMAN. I mean here we are hearing——

Mr. WOOL. Sure.

The CHAIRMAN [continuing] that the company or the group was disintegrating, and that is a matter of pride for the trustees, the executives, I am sure, the members with long associations, with families, and physicians. I understand there is an institutional memory here that doesn't go unrecognized.

On the other hand, there is pretty adequate testimony that this is not financially the healthiest group in the world. We have just heard Humana and your executives say their principle concern was for those people who would be the most vulnerable and have the toughest time getting other insurance, and I am happy about that.

Federal employees—every year I can pick from a variety of plans, so I am covered. Okay? I am safe. You don't have to worry about me. You have to pay for my insurance through your taxes, but you don't have to worry about me.

Now, what would you have done? Do you feel that you could have continued, as the trustees, GHA and felt secure that these vulnerables who without this guarantee—if GHA went under, wouldn't have anybody to take them? Now is that a risk you were willing to assume when you wanted to continue the operation?

Mr. WOOL. Well, we first of all, feel quite strongly that, of course, there is always a risk, but that risk has been grossly overstated by the people promoting the sale.

Second, I want to emphasize that some of the planning concerning the expenditure of funds, assuming the sale goes through, is premature. We do have a suit on file in the DC Superior Court challenging, for some of the reasons I briefly noted, the validity of the last referendum.

We have to emphasize that the financial resources of Group Health are still substantial. The value of Group Health includes, certainly, its 132,000 contracts, if you will, but also includes much more than that, and there are in motion plans which we feel very confident with proper, motivated leadership will turn around this organization. Perhaps not only permit it to continue as an individual organization, but to have time to choose alliances under the new health reform system which may be even more compatible with some of our basic values.

So I think that is a direction we could go. I can't give you any forecast of what would happen if Group Health went under because I really don't know the extent to which there would be alternative protections available under the laws of the States and the District of Columbia.

The CHAIRMAN. Mr. Pfotenhauer, can you tell me—I am sure it is in some of those documents somewhere—what value has been ascribed to the subscription list, if you will? Can you place a dollar value or have you?

Mr. PFOTENHAUER. Off the top of my head I would have to do some math like you tried a few minutes ago, Mr. Chairman. That clearly is a very substantial portion of the overall assets. There are fixed assets that do have value. We own property in Marlowe Heights in Prince George's County.

The CHAIRMAN. I am not talking about those. I am just talking about the list.

Mr. PFOTENHAUER. Right.

The CHAIRMAN. You know, like you buy a newspaper. I am not talking about the printing presses, I am just talking about the subscription list.

Mr. PFOTENHAUER. What I am about to say is that the real estate does certainly have value, but I think from a business standpoint, from the strategic investment that Humana clearly is making, the substantial value is tied to the enrollee contracts as well as a very dedicated work force, and certainly a provider group that is the primary reason that most of our members have stuck around for 10, 20 and 30 years, because of their physician relationship.

The CHAIRMAN. Doctor, what do you think it is worth?

Dr. LANKFORD. Well, I am not the finance guy so I am probably not well-versed to be able to——

The CHAIRMAN. Let me try this.

Dr. LANKFORD. It is more difficult in a staff model or——

The CHAIRMAN. Yes. Let me try it this way, though. What's the average standard or traditional compensation plan for an agent? Or do you know the marketing costs of Humana, in general? What are your marketing costs; 15 percent?

Dr. LANKFORD. I don't do marketing.

The CHAIRMAN. Well, but you are an executive. Are you on the board of Humana?

Dr. LANKFORD. No.

The CHAIRMAN. Oh, you are not. You should be. [Laughter].

Absolutely. You have the demeanor and you testify well.

It's got to be 10 percent, anyway?

Dr. LANKFORD. Of total premium for marketing?

The CHAIRMAN. What do you pay an agent? You pay a little more up front for the first guy you get? I don't know.

Dr. LANKFORD. Three percent of premium may go to the marketing department, and that includes staff and media.

The CHAIRMAN. Yes. Okay. But is there a front-end load on that? In other words, you get a new member, does the salesman—he has to get more, if he is selling—get a $2,000 commission? The guy has to get more than $60? Huh? For a salesman that really goes out and hustles for that, 3 percent, $60. Right?

Dr. LANKFORD. Maybe higher if it is Medicare.

The CHAIRMAN. Okay. Well that's 1, 2, 3, 12 19—that's $7 million or $8 million bucks right there, isn't it?

So we ought to be able, Mr. Pfotenhauer, and Ms. Kane—if I give you 132,000 enrollees, and let's say they are going to pay $2,000, so let's see, 3 percent of $2,000 is 60 times 132, that is almost $8 million, not counting the real estate. How do you like that?

How do you do it, Mr. Pfotenhauer? You got them up to $8 million—I mean there is $8 million clear,no problems, no residuals.

Mr. PFOTENHAUER. I think the overall offer of $50 million, of which a substantial portion is cash——

The CHAIRMAN. Cash. Yes.

Mr. PFOTENHAUER [continuing] and assumption of liabilities, was clearly a fair market value offer. Some might suggest it was even a premium offer that might have been tied to their interest.

The CHAIRMAN. I wouldn't have any way to judge it. I am just trying to figure out what——

Mr. PFOTENHAUER. But clearly for the transaction to be completed, I think an important point to emphasize is that John Nuveen & Company, which served as the financial advisers to the board, will be rendering an opinion, a fairness opinion on the transaction. That becomes a very critical piece of completing the deal, and they are prepared to render that fairness opinion.

The CHAIRMAN. Let me ask you this, just out of curiosity. If they are wrong, these characters who are going to give you this opinion, have they got any of their own money on the table? What happens to them if they are off by——

Mr. PFOTENHAUER. Well, I am not an attorney, Mr. Chairman, but my understanding is that given the trends in litigation on ac-

counting firms and law firms rendering opinions, that there would be some substantial liability facing John Nuveen if they were challenged on this in court and found to be rendering an opinion that was improper.

The CHAIRMAN. Well, I will bet you that it is not.

Mr. PFOTENHAUER. Pardon?

The CHAIRMAN. I will bet you it doesn't exist or they wouldn't be offering it in a private area. But that is a matter——

Mr. PFOTENHAUER. Well, there are two points to it. One is the actual amount, and Nuveen does have a valuation model they apply to any transaction. The other very salient point is that this was done at arm's length. There were 12 potential bidders who were in the give and take. This was not offered exclusively to Humana.

The CHAIRMAN. Oh, I thought you said that is how you selected Nuveen.

Mr. PFOTENHAUER. They were selected through a competitive bid process.

The CHAIRMAN. That is great. Okay.

Well, if anybody has any final remarks, any of the staff have anything they would like to add, I feel about as well-informed now as I did earlier this morning. But I am somewhat reassured, I must say, by Mr. Pfotenhauer's suggestion that the people with whom the government should be most concerned will be looked after.

I am reassured, Mr. Wool, that you and Ms. Kane will have that $10 million to make life a little better for people in the area. I think that sounds like it ought to do all right for the community.

Did you have a question? If you do, go right ahead.

Counsel for the minority will inquire.

Mr. SMITH. Just one question for Ms. Kane and Mr. Wool.

The CHAIRMAN. Sure.

Mr. SMITH. There does still seem to be somewhat of a difference of opinion about the financial condition of GHA. Was there any independent outside consultant hired by the board or the trustees or the membership committee or anything that independently looked at the financial condition?

Ms. KANE. Let me clarify. I came on the board in June of this year. I was selected to the board in May and officially became a member of the board in June, and the board had already had on board John Nuveen & Company that was advising it about the——

Mr. SMITH. That was about the sale, though, right?

Ms. KANE. Well, about the value. The value of the organization and the attractiveness of it to potential bidders, et cetera. So I really came on board a train that was 90 percent down the track already.

Mr. SMITH. But was there, in addition to that, independent outside advisers?

Ms. KANE. Not that I am aware of.

Mr. SMITH. Mr. Wool?

Mr. WOOL. We did recommend that we call in somebody to do an independent financial assessment. This was about a year and a half ago. A consultant who had been formerly the head of an HMO and was then in the consulting business was recommended to us, and

we agreed with Mr. Pfotenhauer—we being the rights committee—to sponsor his assessment.

He ended up by endorsing the for-profit conversion plan, but I must admit I was very disappointed in his process. Before he even came down to Washington, I think he had prepared his briefing based entirely upon information provided by management. So I really, in retrospect, feel that it wasn't a completely independent consultant.

Mr. SMITH. When was that?

Mr. WOOL. That was done about a year ago. A year—let's see. Yes, approximately about a year ago.

Mr. SMITH. The consultant himself also, after looking at the decline in membership and looking at the balance sheet, did advise the membership committee and the trustees that indeed there was a problem that needed to be addressed?

Mr. WOOL. Yes.

Mr. SMITH. Thank you. No further questions.

The CHAIRMAN. I want to thank the panel very much for their willingness to cooperate and be forthcoming. It is helpful.

Our final panel will consist of two witnesses. Mr. William Broglie, who is the Director of the Office of Prepaid Health Care Operations and Oversight, from HCFA, the affectionate name for the Health Care Financing Administration; and Mr. Robert Willis, who is the superintendent of insurance for the District of Columbia.

Hopefully, our panel will inform us about which authorities should review these types of deals and what the focus of the triumvirate of the District of Columbia, Maryland and Virginia insurance regulators might look for, the extent of oversight of the operations of HMOs, and what they might suggest to us both for the District and perhaps for Federal legislation to ensure that in the future the interests of the beneficiaries are accommodated.

Mr. Broglie, would you like to lead off?

PANEL FOUR, CONSISTING OF WILLIAM BROGLIE, DIRECTOR, OFFICE OF PREPAID HEALTH CARE OPERATIONS AND OVERSIGHT, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND ROBERT M. WILLIS, SUPERINTENDENT OF INSURANCE, DISTRICT OF COLUMBIA

STATEMENT OF WILLIAM BROGLIE

Mr. BROGLIE. Yes. Good afternoon, Mr. Chairman. As Director of the Office of Prepaid Health Care Operations and Oversight in the Health Care Financing Administration, our office has responsibility for administration and oversight of the Medicare managed care program and the Federal HMO qualification program.

Under the Medicare managed care program, we have oversight responsibility for nearly 190 contracting HMOs and managed care plans. We are charged with ensuring that organizations initially meet statutory and regulatory requirements for contracting with Medicare. We also conduct an ongoing monitoring and enforcement program to ensure that Medicare contracting plans continue to meet performance requirements.

Under the Federal HMO qualification program, we make initial determinations that managed care plans seeking Federal qualification meet statutory and regulatory requirements. However, unlike our role in the Medicare managed care program, we do not conduct an ongoing monitoring program for federally qualified HMOs except with regard to physical solvency or in response to member complaints.

There are approximately 420 federally qualified HMOs encompassing 35 million enrollees.

Group Health Association was granted Federal qualification in July 1977. They also signed an agreement with HCFA in 1983 to serve Medicare beneficiaries as a health care prepayment plan and, as of August 1993, they have approximately 8,153 Medicare beneficiaries as members.

We initiated an investigation of GHA in September 1991, because of concerns about the organization's fiscal soundness. GHA submitted a corrective action plan in April of this year, and that corrective action plan was approved by our office. We have, however, continued to monitor GHA's progress in addressing the financial issues which led to the initial investigation.

Our typical responsibility when there is a merger or acquisition is if the organization that emerges from that acquisition or merger is seeking Federal qualification. We go in and do an initial review to make sure that they meet the HMO qualification requirements, such as having an adequate health services delivery network, ensuring that they are a fiscally sound organization, ensuring that they have a member appeals process in place and although I do not know the details of the acquisition plan that is contemplated between Humana and GHA, that is what I would expect to occur in this instance.

That concludes my testimony.

STATEMENT OF ROBERT M. WILLIS

Mr. WILLIS. Good afternoon, Mr. Chairman. My name is Robert Willis. I am insurance superintendent of the District of Columbia. Thanks for inviting me to appear before you today and to discuss in general terms the insurance regulatory issues surrounding the proposed acquisition of Group Health by Humana.

My testimony today will not explore any specifics of the proposed transaction since I am currently engaged in the process of beginning to review the feasibility of this transaction.

I would also like to address how I see the role of insurance regulation as applied to health maintenance organizations and some aspects of the HMO market that are of particular concern to me and, I expect, the committee.

Historically, just to go through that briefly, in 1939 the then Superintendent Jordan of the District of Columbia sued GHA, arguing that since the company was acting like an insurance company it should be regulated as such. GHA argued that it was only a provider of health services and that it was an organization formed for the purpose of bringing together affordable health care services under one umbrella to its members.

Obviously, Superintendent Jordan was unsuccessful in persuading the court that GHA was an insurance company. As a result, a legal precedent was established in the District causing all subsequent superintendents not to attempt to regulate GHA or other HMOs operating in the District.

Historically, GHA has structured itself as a staff/group model HMO and appears to have served its members well. However, the viability of GHA is quite different today in a fully competitive environment. Active competition now exists in the form of group models, mixed models, and in independent practice models. The mixed and independent models appear to be fully capable of undercutting the price of the GHA staff/group model and have begun penetrating the GHA market and attracting a large number of its enrollees.

Given the intensity of competition within the District HMO market, GHA has had to make some very difficult choices. As I understand it, the choices are to be acquired to obtain the infusion of needed capital from other sources outside GHA or to reconfigure the current structure so that GHA can compete on a price basis with other HMOs without adversely affecting its financial condition or quality of care.

As you are aware, the District of Columbia does not currently have a statute regulating health maintenance organizations. In order to close this regulatory loophole, I formed last year an HMO working group to assist me in drafting a proposed statute. This proposed statute focuses on regulating the financial condition of HMOs and specifically addresses issues such as acquisitions and holding company ownership.

In general, my review of the proposed GHA acquisition will focus primarily on the financial condition of the surviving entity, which as proposed in this case would be Humana. As in the case with any transaction of this nature, my review will focus heavily on after-acquisition factors such as rate stability over a period of time, maintaining the quality of coverage that currently exist today, and the impact on provider networks.

Quite obviously, some adjustments would occur to meet competitive and profitability objectives. The question becomes where and how.

As I see it, the regulatory process would also require what I will label as financial due diligence to ensure the acquiring entity can meet the obligations assumed under the transaction. Also, an evaluation would be made of the acquiring company's management experience with the sought after business, and then other environmental considerations such as the regulatory approvals, which in this instance would require an acknowledgment, if not absolute approval, by regulators in both Maryland and Virginia.

In my opinion, proper regulation must candidly assess GHA's current financial condition and prospects of success with or without the proposed transaction. The focus must be the adequate protection of the GHA membership in assessing strategies to guard against the potential impacts of a GHA failure on the provider community throughout the Washington Metropolitan Area.

Mr. Chairman, and members of the committee, let me assure you that as in the case of extending regulatory authority over the Blue

Cross and Blue Shield of the National Capital area, every effort will be made to cause GHA to become financially solvent so that it can remain a viable HMO within the Washington market.

With this committee's indulgence, I respectfully ask that we be allowed to continue similar efforts regarding the proposed GHA acquisition.

Next, Mr. Chairman, I'd like to address the experiences HMOs have had with regard to the traditionally underserved populations. I fully agree that HMO services to underserved populations need to be given strong consideration when we discuss how to reform our health care delivery systems.

Traditionally, health care delivery to the underserved population has been relegated to Federal and State funded public health clinics, emergency rooms, and to Hill-Burton types of coverage. The Federal Government, in recognizing the reluctance of traditional HMOs to enroll the underserved population, authorized the establishment of public health care clinics and granted to the Department of Health and Human Services the authority to regulate and manage them. Within the District of Columbia three such clinics were established. Today all three have combined to form one large clinic network that services all of Washington, DC.

The mandate imposed on these clinics was that they were required to be established in special impact areas where the underserved resided and to provide primary and preventive care services on a sliding fee basis.

Although many of the clinics established themselves pursuant to these Federal guidelines, they were generally unsuccessful in incorporating an appropriate mix consisting of members who paid at the upper end of the sliding scale as well as those members paying at the subsidized rate. They simply lacked the ability to adequately subsidize members paying at a reduced rate.

The experience of these federally sponsored public health clinics give some clues as to why traditional HMOs have been reluctant to cover the underserved population.

The traditional HMOs were unwilling to increase enrollment fees enough to subsidize the capitated reimbursement rate paid on behalf of the underserved population. Moreover, I believe HMOs fear the loss of a competitive price advantage over traditional health insurance products.

The questions an HMO had to ask was how much more could be charged to regular enrollees to adequately subsidize the capitated payments received on behalf of the underserved population? Moreover, what percentage of the patient population mix consisting of capitated patients could be absorbed without being forced into insolvency.

As is evident by the HMO experience and response to these questions, an ever-increasing number of the underserved population have been forced to seek treatment in emergency rooms for all levels of care or to go without treatment altogether.

Certainly, in today's health care environment, there are few HMOs that are willing to enroll Medicaid members. In the District of Columbia one HMO services the entire Medicaid population.

The CHAIRMAN. Which one is that?

Mr. WILLIS. That is the Chartered Health Plan.

The CHAIRMAN. They have what, 15,000?

Mr. WILLIS. That is approximately correct, yes.

More recently, some HMOs appear to have been structuring themselves to exclusively target Medicaid and Medicare markets. These HMOs believe they can be successful and remain solvent by more stringently managing health care and by encouraging government to increase the rates of reimbursement. Some jurisdictions are moving toward reimbursing HMOs at a capitated rate of 95 percent of UCR rather than the traditional 50 to 60 percent.

Mr. Chairman, I want to again reiterate that as an insurance regulator my primary concern is the financial condition and market conduct of HMOs. The HMO structure imposes a risk of loss onto the public which is dramatically different than the risk of loss imposed by legal reserve insurance companies.

Admittedly, we don't frequently read about health plans going out of business. However, when we do it becomes painfully clear that the impact is severe. The severity is caused primarily by a shortage of reserves. In general, HMOs are only required to post a 90-day reserve even though the promise made to the public is for more than 1 year.

Since it appears that the future of health care delivery in America is about to undergo a significant change, there will clearly be the need to regulate the financial condition and market conduct of the resulting purchasing cooperatives, alliances, accountable health plans, et cetera.

If we move toward a system which does not adequately protect against the risk of loss via the posting of statutory reserves by HMOs to cover the full extent of the promises that they make, we will have created a system requiring even more regulation of HMOs in order to monitor their financial condition and likelihood of insolvencies.

That concludes my testimony. I am available to answer any questions you may have.

[The prepared statement of Mr. Willis follows:]

STATEMENT OF

ROBERT M. WILLIS, DISTRICT OF COLUMBIA COMMISSIONER

ON

PROPOSED SALE OF GROUP HEALTH ASSOCIATION TO HUMANA

SEPTEMBER 14, 1993

GOOD MORNING CHAIRMAN STARK AND MEMBERS OF THE COMMITTEE ON THE DISTRICT OF COLUMBIA. MY NAME IS ROBERT M. WILLIS AND I AM THE COMMISSIONER OF INSURANCE FOR THE DISTRICT OF COLUMBIA. THANK YOU FOR INVITING ME TO APPEAR BEFORE YOU TO DISCUSS, IN GENERAL, THE INSURANCE REGULATORY ISSUES SURROUNDING THE PROPOSED ACQUISITION OF GROUP HEALTH ASSOCIATION, INC. ("GHA"), A DISTRICT OF COLUMBIA NON-PROFIT CORPORATION, BY HUMANA, INC. ("HUMANA"), A FOR-PROFIT CORPORATION. MY TESTIMONY TODAY WILL NOT EXPLORE ANY SPECIFICS OF THE PROPOSED ACQUISITION SINCE I AM CURRENTLY ENGAGED IN THE PROCESS OF BEGINNING TO REVIEW THE FEASIBILITY OF THIS TRANSACTION.

I WOULD ALSO LIKE TO ADDRESS HOW I SEE THE ROLE OF INSURANCE REGULATION AS APPLIED TO HEALTH MAINTENANCE ORGANIZATIONS (HMOS) AND SOME ASPECTS OF THE HMO MARKET OF PARTICULAR CONCERN TO ME, AND I EXPECT THE COMMITTEE.

IN 1939 SUPERINTENDENT JORDAN, THE THEN SUPERINTENDENT OF INSURANCE FOR THE DISTRICT OF COLUMBIA, SUED GHA ARGUING THAT SINCE THE COMPANY WAS ACTING LIKE AN INSURANCE COMPANY IT

SHOULD BE REGULATED AS SUCH. GHA ARGUED THAT IT WAS ONLY A PROVIDER OF HEALTH CARE SERVICES AND THAT IT WAS AN ORGANIZATION FORMED FOR THE PURPOSE OF BRINGING TOGETHER AFFORDABLE HEALTH CARE SERVICES UNDER ONE UMBRELLA TO ITS MEMBERS.

QUITE OBVIOUSLY, SUPERINTENDENT JORDAN WAS UNSUCCESSFUL IN PERSUADING THE COURT THAT GHA WAS AN INSURANCE COMPANY. AS A RESULT, A LEGAL PRECEDENCE WAS ESTABLISHED IN THE DISTRICT CAUSING ALL SUBSEQUENT SUPERINTENDENTS NOT TO ATTEMPT TO REGULATE GHA OR ANY OTHER HMO OPERATING IN THE DISTRICT OF COLUMBIA.

BASED ON MY UNDERSTANDING OF THE GHA ORGANIZATION, STRUCTURALLY, LITTLE HAS CHANGED SINCE ITS INCEPTION. GHA ESTABLISHED ITSELF AS A CONDUIT FOR HEALTH CARE DELIVERY TO TAKE ADVANTAGE OF ECONOMIES OF SCALE AT A TIME WHEN THIS IDEA WAS NEW AN INNOVATIVE. HISTORICALLY, GHA STRUCTURED ITSELF AS A STAFF GROUP MODEL HMO AND APPEARS TO HAVE SERVED ITS MEMBERS WELL. HOWEVER, THE VIABILITY OF GHA IS QUITE DIFFERENT TODAY IN A FULLY COMPETITIVE MARKETPLACE. ACTIVE COMPETITION NOW EXISTS IN THE FORM OF GROUP MODELS, MIXED MODELS AND INDEPENDENT PRACTICE MODELS. THE MIXED AND INDEPENDENT MODELS APPEAR TO BE FULLY CAPABLE OF UNDERCUTTING THE PRICE OF THE GHA STAFF GROUP MODEL AND HAVE BEGUN PENETRATING THE GHA MARKET AND ATTRACTING A LARGE NUMBER OF ITS ENROLLEES.

GIVEN THE INTENSITY OF COMPETITION WITHIN THE DISTRICT'S HMO MARKET, GHA HAS HAD TO MAKE SOME VERY DIFFICULT CHOICES. ALTHOUGH A MINORITY OF ITS MEMBERSHIP OPPOSES THE PROPOSED ACQUISITION, AS I UNDERSTAND IT, THE CHOICES ARE TO BE ACQUIRED, OBTAIN THE INFUSION OF NEEDED CAPITAL FROM OTHER OUTSIDE SOURCES OR RECONFIGURE THE CURRENT STRUCTURE SO THAT GHA CAN COMPETE ON A PRICE BASIS WITH OTHER HMOS WITHOUT ADVERSELY EFFECTING ITS FINANCIAL CONDITION OR THE QUALITY OF CARE IT PROVIDES.

REGARDING THE FINANCIAL IMPACT OF THIS COMPETITION, I THINK IT IS FAIR TO SAY THAT THE WARNING LIGHTS HAVE BEEN FLASHING FOR A FEW YEARS. GHA APPEARS TO HAVE SAILED INTO SHALLOW WATERS AND NOW THE QUESTION IS WHETHER IT CAN, ON ITS OWN, STEER ITSELF BACK INTO A FINANCIALLY SAFE HABOR OR OBTAIN THE HELP OF A FINANCIAL SUITOR.

AS YOU ARE AWARE, THE DISTRICT OF COLUMBIA DOES NOT CURRENTLY HAVE A STATUTE REGULATING HMOS. IN ORDER TO CLOSE THIS REGULATORY LOOP HOLE I FORMED AN HMO WORKING GROUP OVER A YEAR AGO TO ASSIST ME IN DRAFTING A PROPOSED STATUTE. I WILL FORWARD THIS PROPOSAL TO THE OFFICE OF CORPORATION COUNSEL FOR REVIEW SHORTLY. THIS PROPOSED STATUTE FOCUSES ON REGULATING THE FINANCIAL CONDITION OF HMOS AND SPECIFICALLY ADDRESSES ISSUES SUCH AS ACQUISITIONS AND HOLDING COMPANY OWNERSHIP.

IN GENERAL, MY REVIEW OF THE PROPOSED GHA ACQUISITION WILL FOCUS PRIMARILY ON THE FINANCIAL CONDITION OF THE SURVIVING HUMANA ENTITY. I WANT TO BE REASONABLY ASSURED THAT THE SURVIVING ORGANIZATION WILL HAVE THE FINANCIAL CAPACITY TO CONTINUE DELIVERING HEALTH CARE SERVICES TO DISTRICT AND WASHINGTON METROPOLITAN ENROLLEES AT A LEVEL OUR PUBLICS HAVE BECOME ACCUSTOMED TO RECEIVING.

AS IN THE CASE WITH ANY TRANSACTION OF THIS NATURE, MY REVIEW WILL FOCUS HEAVILY ON AFTER ACQUISITION FACTORS, SUCH AS RATE STABILITY, MAINTAINING THE QUALITY OF COVERAGES AND THE IMPACTS ON PROVIDER NETWORKS. QUITE OBVIOUSLY, SOME ADJUSTMENTS WOULD OCCUR TO MEET COMPETITIVE AND PROFITABILITY OBJECTIVES. THE QUESTION BECOMES WHERE AND HOW.

AS I SEE IT, THE REGULATORY PROCESS WOULD ALSO REQUIRE FINANCIAL DUE DILIGENCE TO ENSURE THE ACQUIRING ENTITY CAN MEET THE OBLIGATIONS ASSUMED UNDER THE TRANSACTION, AN EVALUATION OF THE ACQUIRING COMPANY'S MANAGEMENT EXPERIENCE WITH THE SOUGHT AFTER LINE OF BUSINESS AND OTHER ENVIRONMENTAL CONSIDERATIONS, SUCH AS THE REGULATORY APPROVALS OF THE MARYLAND AND VIRGINIA INSURANCE REGULATORS.

IN MY OPINION, PROPER REGULATION MUST CANDIDLY ASSESS GHA'S CURRENT FINANCIAL STATUS AND PROSPECTS OF SUCCESS WITH OR WITHOUT THE PROPOSED TRANSACTION. THE FOCUS MUST BE THE

ADEQUATE PROTECTION OF THE GHA MEMBERSHIP AND ASSESSING STRATEGIES TO GUARD AGAINST THE POTENTIAL IMPACTS OF A GHA FAILURE ON THE PROVIDER COMMUNITY THROUGHOUT THE WASHINGTON METROPOLITAN AREA.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE LET ME ASSURE YOU THAT, AS IN THE CASE OF EXTENDING REGULATORY AUTHORITY OVER BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA, EVERY EFFORT WILL BE MADE TO CAUSE GHA TO BECOME FINANCIALLY SOLVENT SO IT CAN REMAIN A VIABLE HMO WITHIN THE WASHINGTON METROPOLITAN AREA. AS YOU KNOW, UNTIL RECENTLY, THE DISTRICT LACKED THE AUTHORITY TO REGULATE BLUE CROSS AND BLUE SHIELD. WHEN THIS POINT WAS MADE KNOWN TO SENATOR NUNN AND THE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS, THAT COMMITTEE INITIATED EFFORTS TO PROVIDE THE DISTRICT AUTHORITY TO ADEQUATELY REGULATE THIS ENTITY. THANKS TO THAT COMMITTEE'S EFFORTS AND THIS COMMITTEE'S STEWARDSHIP AND SUPPORT, WE NOW HAVE THE AUTHORITY TO FULLY REGULATE THE BLUE CROSS AND BLUE SHIELD OF THE NATIONAL CAPITAL AREA PLAN. WITH THE ASSISTANCE OF NEW MANAGEMENT, WE HAVE BEGUN THE PROCESS OF CAUSING THIS ORGANIZATION TO MOVE FURTHER AND FURTHER AWAY FROM THE FINANCIAL DIFFICULTIES IT HAD BEEN EXPERIENCING. WITH THIS COMMITTEE'S INDULGENCE, I RESPECTFULLY ASK THAT WE BE ALLOWED TO CONTINUE SIMILAR EFFORTS REGARDING THE PROPOSED GHA ACQUISITION.

NEXT, CHAIRMAN STARK AND MEMBERS OF THE COMMITTEE, I WOULD LIKE TO ADDRESS THE EXPERIENCE HMOS HAVE HAD WITH REGARD TO TRADITIONALLY UNDERSERVED POPULATIONS AND TO PRESENT MY VIEWSOF WHAT MIGHT BE IN STORE FOR THE FUTURE. I FULLY AGREE THAT HMO SERVICES TO UNDERSERVED POPULATIONS NEEDS TO BE GIVEN STRONG CONSIDERATION WHEN WE DISCUSS HOW TO REFORM OUR HEALTH CARE DELIVERY SYSTEMS.

TRADITIONALLY, HEALTH CARE DELIVERY TO THE UNDERSERVED POPULATION HAS BEEN RELEGATED TO FEDERAL AND STATE FUNDED PUBLIC HEALTH CLINICS, EMERGENCY ROOMS AND TO HILL BURTON COVERAGE. IF OUR HEALTH CARE DELIVERY SYSTEM IS TO BE APPROPRIATELY MANAGED, WE MUST GIVE STRONG CONSIDERATION TO MANAGING AN ENTIRE SYSTEM RATHER THAN TO SUBDIVIDING IT INTO TWO PARTS; THE PART FOR THOSE WHO CAN AFFORD HEALTH CARE AND THE PART FOR THOSE WHO CANNOT.

THE HMO CONCEPT REALLY DIDN'T CATCH ON IN AMERICA UNTIL IT ARRIVED FROM THE SHORES OF SCANDINAVIA AND TOUTED AS THE ALTERNATIVE TO OUR TRADITIONAL HEALTH CARE DELIVERY SYSTEM. UNTIL RECENTLY, I DON'T BELIEVE THAT IT WAS EVER PROMOTED AS A SOURCE FOR PROVIDING HEALTH CARE TO TRADITIONALLY UNDERSERVED POPULATIONS.

THE HMO CONCEPT FOCUSES HEAVILY ON COST ISSUES, SUCH AS ENHANCING EFFICIENCY AND MAXIMIZING ECONOMIES OF SCALE FOR ENROLLEES WHO COULD AFFORD TO PAY THE REQUISITE MEMBERSHIP

FEES. THE IDEA WAS TO PROVIDE AN ECONOMICALLY FEASIBLE ALTERNATIVE TO A PLETHORA OF INDEPENDENT AND SMALL GROUP PHYSICIANS WHO HAD THE COMBINED RESPONSIBILITY OF PRACTICING MEDICINE AND MANAGING A BUSINESS.

THE FEDERAL GOVERNMENT, RECOGNIZING THE RELUCTANCE OF TRADITIONAL HMOS TO ENROLL THE UNDERSERVED POPULATION, AUTHORIZED THE ESTABLISHMENT OF PUBLIC HEALTH CARE CLINICS AND GRANTED THE DEPARTMENT OF HUMAN AND HEALTH SERVICES THE AUTHORITY TO REGULATED AND MANAGE THEM. WITHIN THE DISTRICT OF COLUMBIA, THREE SUCH CLINICS WERE ESTABLISHED. THE UPPER CARDOZA NEIGHBORHOOD HEALTH CLINIC, THE SHAW NEIGHBORHOOD HEALTH CLINIC AND THE EAST OF THE RIVER NEIGHBORHOOD HEALTH CLINIC. TODAY, ALL THREE HAVE COMBINED TO FORM ONE LARGE CLINIC NETWORK THAT SERVICES ALL OF WASHINGTON, D.C.

THE MANDATE IMPOSED UPON THESE CLINICS WAS THAT THEY WERE REQUIRED TO BE ESTABLISHED IN SPECIAL IMPACT AREAS WHERE THE UNDERSERVED RESIDED AND TO PROVIDE PRIMARY AND PREVENTATIVE CARE SERVICES ON A SLIDING FEE BASIS.

ALTHOUGH MANY OF THE CLINICS ESTABLISHED THEMSELVES PURSUANT THESE FEDERAL GUIDELINES, THEY WERE GENERALLY UNSUCCESSFUL AT INCORPORATING AN APPROPRIATE MIX CONSISTING OF MEMBERS WHO PAID AT THE UPPER END OF THE SLIDING SCALE AS

WELL AS THOSE MEMBERS PAYING AT THE SUBSIDIZED RATE. THE INABILITY TO ATTRACT FULL PAYING MEMBERS PLACED SEVERE HARDSHIPS ON THESE FEDERALLY FUNDED CLINICS. THEY SIMPLY LACKED THE ABILITY TO ADEQUATELY SUBSIDIZE THE MEMBER PAYING AT A REDUCED RATE.

THE EXPERIENCE OF THESE FEDERALLY SPONSORED PUBLIC HEALTH CLINICS GIVES SOME CLUES AS TO WHY TRADITIONAL HMOS HAVE BEEN RELUCTANT TO COVER THE UNDERSERVED POPULATION. THE TRADITIONAL HMOS WERE UNWILLING TO INCREASE ENROLLMENT FEES ENOUGH TO SUBSIDIZE THE CAPITATED REIMBURSEMENT RATE PAID ON BEHALF OF THE UNDERSERVED POPULATION. MOREOVER, I BELIEVE HMOS FEARED THE LOSS OF A COMPETITIVE PRICE ADVANTAGE OVER TRADITIONAL HEALTH INSURANCE PRODUCTS AND THE INCREASED RISK OF INSOLVENCY BECAUSE OF THEIR OWN BUILT IN PRICING STRUCTURE. THE QUESTION HMOS HAD TO ASK WAS HOW MUCH MORE COULD BE CHARGED TO REGULAR ENROLLEES TO ADEQUATELY SUBSIDIZE THE CAPITATED PAYMENTS RECEIVED ON BEHALF OF THE UNDERSERVED POPULATION? MOREOVER, WHAT PERCENTAGE OF THE PATIENT POPULATION MIX CONSISTING OF CAPITATED PATIENTS COULD BE ABSORBED WITHOUT BEING FORCED INTO INSOLVENCY?

AS IS EVIDENT BY THE HMO EXPERIENCE AND RESPONSE TO THESE QUESTIONS, AN EVER INCREASING NUMBER OF THE UNDERSERVED POPULATION HAVE BEEN FORCED TO SEEK TREATMENT IN EMERGENCY ROOMS FOR ALL LEVELS OF CARE OR TO GO WITHOUT TREATMENT ALTOGETHER.

CERTAINLY, IN TODAY'S HEALTH CARE ENVIRONMENT, THERE ARE ALL TO FEW HMOS THAT ARE WILLING TO ENROLL MEDICAID MEMBERS. IN THE DISTRICT OF COLUMBIA, ONLY ONE HMO SERVICES THE MEDICAID POPULATION. HOWEVER, MORE RECENTLY, SOME HMOS APPEAR TO BE STRUCTURING THEMSELVES TO EXCLUSIVELY TARGET THE MEDICAID AND MEDICARE MARKETS. THESE HMOS BELIEVE THEY CAN BE SUCCESSFUL AND REMAIN SOLVENT BY MORE STRINGENTLY MANAGING THE DELIVERY OF HEALTH CARE AND BY ENCOURAGING GOVERNMENT TO INCREASE THE RATES OF REIMBURSEMENT. SOME JURISDICTIONS ARE MOVING TOWARDS REIMBURSING HMOS AT A CAPITATED RATE OF 95% OF UCR RATHER THAN THE TRADITIONAL 50% TO 60%.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE I WANT TO AGAIN REITERATE THAT, AS AN INSURANCE REGULATOR, MY PRIMARY CONCERN IS WITH THE FINANCIAL CONDITION AND MARKET CONDUCT OF HMOS. THE HMO STRUCTURE IMPOSES A RISK OF LOSS ONTO THE PUBLIC WHICH IS DRAMATICALLY DIFFERENT THAN THE RISK OF LOSS IMPOSED BY LEGAL RESERVE INSURANCE COMPANIES. THE NATURE OF THE HMO RISK IS PURELY FINANCIAL, WHICH TRANSLATES INTO A HIGHER PROBABILITY OF SEVERE IMPACT THAN MIGHT BE EXPERIENCED WITH LEGAL RESERVE INSURANCE COMPANIES.

ADMITTEDLY, WE DON'T FREQUENTLY READ ABOUT HEALTH PLANS GOING OUT OF BUSINESS. WHEN WE DO, IT BECOME PAINFULLY CLEAR THE IMPACT IS SEVERE. THIS SEVERITY IS CAUSED PRIMARILY BY A SHORTAGE OF RESERVES. IN GENERAL, HMOS ARE ONLY REQUIRED TO POST A 90 DAY RESERVE EVEN THOUGH THE PROMISE MADE TO ITS MEMBERS IS FOR ONE YEAR.

SINCE IT APPEARS THAT THE FUTURE OF HEALTH CARE DELIVERY IN AMERICA IS ABOUT TO UNDERGO A SIGNIFICANT CHANGE, THERE WILL CLEARLY BE THE NEED TO REGULATE THE FINANCIAL CONDITION AND MARKET CONDUCT OF THE RESULTING PURCHASING COOPERATIVES AND ACCOUNTABLE HEALTH PLAN ORGANIZATIONS.

IF WE MOVE TO A SYSTEM WHICH DOES NOT ADEQUATELY PROTECT AGAINST THE RISK OF LOSS VIA THE POSTING OF STATUTORY RESERVES TO COVER THE FULL EXTENT OF THE PROMISES BEING MADE, WE WILL HAVE CREATED A SYSTEM REQUIRING EVEN MORE REGULATION TO MONITOR THE HMO FINANCIAL CONDITION BECAUSE OF THE INCREASED LIKELIHOOD OF INSOLVENCIES.

I AM AVAILABLE TO ANSWER YOUR QUESTIONS.

The CHAIRMAN. Thank you.

Mr. Broglie, where were you when IMC stole all that money?

Mr. BROGLIE. Fortunately, not in my current position. I was actually in the Office of Research and Demonstrations in HCFA at the time.

The CHAIRMAN. Researching whether they were going to go broke or not.

Let me just see if I understand. Your only handle on an HMO is if it has a risk contract or a cost reimbursement contract?

Mr. BROGLIE. No. Actually, we have two distinct programs that we have responsibility for.

The CHAIRMAN. Okay.

Mr. BROGLIE. The risk or cost program, where an HMO contracts with Medicare to serve Medicare beneficiaries, is one program. In addition, if an HMO wants to come in and seek Federal qualification, which is not at all linked to having a Medicare contract, we also are responsible for administering that program.

The CHAIRMAN. If I want to take my Medicare benefits and join a federally qualified one as an individual, if they would take me, how do you pay them? Same way you pay a risk contractor?

Mr. BROGLIE. The only way that we as the Medicare program would pay for your benefits as a Medicare beneficiary as part of an HMO, would be if you were enrolled in a Medicare contracting HMO.

The CHAIRMAN. Risk contractor cost contracted?

Mr. BROGLIE. Cost; correct.

The CHAIRMAN. So, where they are qualified, it just means that they can bill you on a fee-for-service the same way any other group could bill you.

Mr. BROGLIE. Federal qualification really doesn't benefit particularly an HMO in terms of dealing with the Medicare population.

The CHAIRMAN. How many HMOs, roughly, have risk contracts?

Mr. BROGLIE. There are around 104 current risk contracting organizations.

The CHAIRMAN. Are some better than others? Do you have more trouble with some than others?

Mr. BROGLIE. Some, if for no other reason than the size of the enrollment population, keep us busier than other plans.

The CHAIRMAN. How many times in the past year have you come up against marketing problems, disenrollment problems, denial of service problems, that have come to your attention? I mean are they significant other than just——

Mr. BROGLIE. In terms of significant problems, none over the past year.

The CHAIRMAN. Previously though, some? Pericelsus—clesis, who are they, in Los Angeles? They are back in business.

Mr. BROGLIE. About a year and a half ago there were some concerns about FHP and their operation in California and their sales marketing practices there.

The CHAIRMAN. Which is either false claims, hustles or things like that.

Do you have rules on that?

Mr. BROGLIE. Yes.

The CHAIRMAN. Do you guys know each other, Mr. Willis? Mr. Broglie?

Mr. BROGLIE. We have met.

The CHAIRMAN. Have you got rules on that?

Mr. WILLIS. Pardon me?

The CHAIRMAN. Do you have rules on marketing these things?

Mr. WILLIS. Mr. Chairman, we do not. As I pointed out, we are in the process of proposing a statute in the District.

The CHAIRMAN. Why don't you give him a copy of your rules? He might be able to crib a few.

I guess the issues that I really want to talk about, my sense is that except as to whether or not Mr. Willis has the right to approve or disapprove this merger or sale and that right would be shared by our neighboring jurisdictions. I am not competent to guess whether you do—I hope you'll assert the right. But whether you have it or not is something for the courts to decide.

Mr. Broglie, do you have any way of controlling the disenrollment?

These guys have a cost contract, so they are under your purview, right? They are going to sell. They are going to sell the list. They told us—you heard them—that they are not going to take any fragile folk and throw them out.

The beneficiaries would be able to go anyplace in the District and get care, wouldn't they, if they are Medicare?

Mr. BROGLIE. That is correct.

The CHAIRMAN. In other words, if they are kicked out they would have to go under fee-for-service if another HMO wouldn't take them, and under our medigap requirements they have to have open enrollment.

So say for the period of open enrollment they could get under a medigap plan that would cover their copays. So you don't really have to worry about your Medicare folk, do you?

Mr. BROGLIE. No. With the cost contract, it is a different situation with the cost contract versus a risk contract. A risk contract, if a risk contract were to either go out of business or stop having a risk contract with us, because typically risk contracts offer supplemental benefits beyond the basic Medicare package, we do make provisions that medigap policies in the area have to make their policies available and without preexisting conditions.

In the case of cost contracts, we do not place any similar requirements on other plans to pick up individuals.

The CHAIRMAN. Even under medigap.

Mr. BROGLIE. That is right.

The CHAIRMAN. Yes, that is right. Six months after you turn 65 you could be selected against. So that is a concern. I mean for right-thinking folks. Right?

I mean that if they boot out a Medicare beneficiary with diabetes or whatever, they might not get their copays covered by another medigap contract.

Mr. BROGLIE. I think the other thing to remember about the contract that GHA has with us is it is a somewhat unique agreement called a health care prepayment plan. Without boring you with all the typical——

The CHAIRMAN. No, you are not boring me at all.

Mr. BROGLIE. There are HMOs that contract with us that provide under the agreement the full range of Medicare covered services, and they are governed by section 1876 of the Social Security Act.

Health care prepayment plans, however, are governed by a different provision of the statute; namely, section 1833 of the Social Security Act. Under that provision they are only required to make arrangements for providing part B Medicare services, and not even the full range of part B Medicare services.

So they go out and for purposes of any inpatient services they obtain those through whatever hospital that they want to get them through.

The CHAIRMAN. Or can.

Mr. BROGLIE. Or can.

The CHAIRMAN. But the hospital has to take them, right?

Mr. BROGLIE. Right.

The CHAIRMAN. Yes.

The CHAIRMAN. The only risk, then, that they would have of getting reasonable coverage would be that they might be denied access to a medigap policy.

Mr. BROGLIE. Yes. That is probably true now, however, because—I am not sure specifically of GHA's provisions, but GHA as a health care prepayment plan does not have to provide or offer or make arrangements for medigap coverage of those individuals now. So it would not surprise me if a large percentage of those enrollees have not on their own already purchased medigap coverage.

The CHAIRMAN. Is there anything in the law we passed regulating medigap providers that prohibits a State from making tougher regulations than the Federal standards? I wrote it but I don't remember it.

Mr. BROGLIE. I am probably not as familiar with it as you are.

The CHAIRMAN. Good idea for you, Mr. Willis.

In other words, as I said, the only concern is, and I think it is fair, that there have been HMOs which have managed to encourage people to leave through procedures that I suspect HCFA would feel are not in the best interests of beneficiaries. Is that a fair statement?

Mr. BROGLIE. That has occurred, and I certainly wouldn't say it is not occurring in isolated instances.

The CHAIRMAN. Not on your watch. You know, you don't look tough. I wish, Mr. Broglie, that you looked meaner. Somehow I would feel more comfortable.

Mr. BROGLIE. My job is not to be tough. The people that work for me, their job is to be tough.

The CHAIRMAN. Okay. But I hope you two would consult on this because, what you have is 50,000 or 60,000 of these people in the District.

Mr. WILLIS. Seventy thousand.

The CHAIRMAN. Yes. It isn't that I don't trust Humana, but people have short memories. That is why we have regulators. I mean if trusting Humana were enough, we wouldn't need Mr. Broglie and we wouldn't need a department of insurance. Right?

So as long as you are there maybe you two could get together and figure out a few things so that we can just make sure that those 72,000 or whatever it is, don't get lost. If you need legislation

to make that easier, I have a hunch that this committee would find it. We are willing to help you as long as it is in the spirit of home rule.

Are you completely comfortable, Mr. Willis, with the laws of the District of Columbia? Do they give you sufficient tools to regulate this variety of insurance companies? There is a dispute in many States about who ought to regulate HMOs; the corporation commissioner?

You are both, aren't you?

Mr. WILLIS. Within the department of consumer and regulatory affairs there is the insurance component as well as the corporate component.

The CHAIRMAN. So you wear both hats?

Mr. WILLIS. That is correct.

The CHAIRMAN. So, you got them either way?

Mr. WILLIS. If I might, Mr. Chairman, on the jurisdictional question, just for the record so that we are clear, currently GHA, Humana and my office are in the process of reviewing a consent order which my attorneys have drafted which would provide the regulatory leverage, if you will, to properly review and supervise this transaction.

Apropos of the Blue Cross and Blue Shield final order, to the extent that there are matters in the public interest that we want to make a permanent record of and to impose as a part of the approval process some conditions, we will certainly not shy away from that responsibility.

So in deference to the role of HCFA, and we will certainly achieve that consulting for purposes of creating a record on sensitive issues, I think my approach would be to record that as a part of the order so that we will all have a sufficient memory of what we agreed to do.

The CHAIRMAN. Okay. I am concerned, and I want to give you a heads up, Mr. Willis, that it was at a previous hearing when the Chair inquired as to the roadblocks and the complications and the problems of my starting an HMO. I found out it is not as complex as one thought. I need $100,000, and it is my understanding that a letter of credit from BCCI would suffice. Then I need to show you, I guess, that I have the proper resources and skills, and it was stipulated that Dr. McDermott, my colleague, who is a licensed physician, would be an adequate resource. The two of us, if we could each stand bail for the $50,000, could become an HMO.

Now, that ought to worry you.

Mr. WILLIS. Well sir, that would not happen in the District.

The CHAIRMAN. You promise me?

Mr. WILLIS. Well, let me show you the color of my metal. The consent order will fully embrace a proposed statute or the proposed statute that I mentioned. It is essentially modeled after the NAIC HMO Act with some flavoring to deal with some particular problems here in the District, including the inclusion of Medicaid recipients more appropriately.

That is part of the consent order that I mentioned. The same law——

The CHAIRMAN. That is how you get it done? You just get a consent order and you are in charge with all these regulations?

Mr. WILLIS. Well sir, it is not quite that simple. I think that there is energy to have the transaction reviewed. The District of Columbia appears to be the appropriate entity to do that. In order to move that process along, we will find appropriate ways in order to cause that review to occur.

The CHAIRMAN. You ought to tell Al Gore about that, and then he could fix that up for Mr. Broglie and we would be able to get stuff done a lot faster. I like that.

Mr. WILLIS. This same law has a minimum capital requirement of $2 million in order to start an HMO in the District.

The CHAIRMAN. You are taking all the fun out of this, Mr. Willis.

Mr. WILLIS. So that in your example, I think we would have to have a more lengthy conversation about your resources. [Laughter].

The CHAIRMAN. Mr. Broglie, I can't let you go—I am concerned and it seems to me back in 1990—as long as I have you here—we talked about regulations and rules on risk contracts as between HMOs and doctors. How are you coming on that?

Mr. BROGLIE. Those regulations are in draft, have been published in draft for some time now. There have been a number of concerns raised.

The CHAIRMAN. They are tough to do, aren't they? I mean to find the right balance?

Mr. BROGLIE. Fortunately that is not my specific area to be responsible for, but judging by the others involved with it they are pretty tough to get out.

The CHAIRMAN. Yes.

Mr. BROGLIE. They have not been published in final yet. There are a number of concerns that the HMO industry itself has raised about what effect, if they were implemented in final as they were drafted, they would have. So we have, I think, made some progress in the fact that they are out in draft now. But they have not been finalized.

The CHAIRMAN. Do you think this year sometime?

Mr. BROGLIE. I would hope so.

The CHAIRMAN. That is good.

On the retroactive disenrollments, do you have those regulations?

Mr. BROGLIE. We have guidelines in place for retroactive disenrollments. We also have underway an effort that we hope to have in place by the beginning part of next calendar year that will actually allow us to start getting information on the nature of the reason an individual disenrolls.

Currently, when an individual disenrolls we know that they did either because they enrolled in another plan, they disenrolled for fee-for-service or they died. One of the concerns we had was that motivation for people disenrolling is the quality of care concern, because of a perception of lack of access to care in the HMO, and we want to start surveying individuals upon disenrollment to learn of the reason and motivation that they had for that. We expect to have that in place, as I said, the early part of next year.

The CHAIRMAN. Super. Thank you.

Are both of you, and I guess more specifically Mr. Willis, comfortable that however this transaction ends up, which certainly this committee has precious little jurisdiction over; you have said, Mr.

Willis I think, that the vulnerable population out of the 132,000 will not be denied coverage or access, just as a result of this changing of the guard. Are you comfortable with that?

Mr. WILLIS. That is certainly my objective in the public interest. I think that where we should all end up, bottom line, is that the effect of this transaction should be transparent relative to the public. That the provider community should not be materially disturbed. Rates should be more stable, and from what I have heard today, given the pricing at GHA versus where Humana has its products in other parts of the country, I would think that there would not be an argument for increases in rates.

That is something we will want to get into, but I think that is a big issue, the rate stability, in accommodating this kind of change. If, in fact, there are economies of scale that can be achieved through a larger flagship, that being Humana, then as a part of the approval process I am looking for reductions and not just strategies to increase costs.

All of that being fairly considered, that is my objective, to make sure we maintain the status quo.

The CHAIRMAN. I wanted to ask you, Mr. Willis, one sort of prospective question. I would love to have Mr. Broglie answer this, but I have to warn him his boss may be concerned with his answer.

It is the intention, the initial suggestion, I suppose, that we can save money and regulate HMOs or preferred providers or managed care plans by limiting the amount of revenue which we give them—set the premiums, in a sense—and taking into account that this would be in an environment in which specific benefits were mandated.

Is that something, Mr. Willis, that gives you any concerns as to what kinds of regulatory tools you will have to assure us that they don't come out even by shortchanging the beneficiaries? Have you thought that process through?

Mr. WILLIS. I have, Mr. Chairman. I think that it certainly begs the question of jurisdiction between insurance departments and departments of health in terms of who will regulate the quality of care.

In your example there really isn't any insurance. It is simply a fee-for-service. There is no risk involved. So I think it is somewhat problematical for insurance regulators to try and figure out where is the beef in the steak, and in our case jurisdictional disputes within government. I have had a similar conversation with some of the White House staff, and it appears that if there is to be a core benefit under national health insurance in order to keep insurance capital interested and achieving some fair rate of return, perhaps the supplemental coverage that would flow from that. I think you create in the market a vacuum, and that is where you will find insurers of all variety wanting to be a part of the national process. Otherwise, I am not sure that you have the incentive.

The CHAIRMAN. It is their intention to define the supplemental products and I gather leave that only to pick up copays, deductibles and a few rather esoteric procedures like private rooms and hair transplants and cosmetic surgery. So I don't think it is the intention in this plan—one where they expect the benefits to be greatly expanded, say, relative to Medicare or Medicaid, so arguably there

wouldn't be much need for supplemental save for the possibility—well, no. I don't think they even anticipate—in the fee-for-service anticipate some copays. But it will be even more stringently regulated than we had with medigap policies under Medicare.

Mr. WILLIS. Mr. Chairman, if we have that kind of arrangement, as I mentioned in my testimony, and assume that kind of product would flow from a health maintenance organization kind of entity, for State insurance regulation that raises a huge solvency issue.

On the one hand, if there are to be some measure of reserve——

The CHAIRMAN. They got that solved too. Because if these guys go broke, they just charge everybody more to put money into the pot. It is a wondrous system.

Mr. WILLIS. It is not consistent with how regulators view solving the so-called guarantee issue.

The CHAIRMAN. Every employer in the District of Columbia will be assessed, if one of your plans get short, to pick up the difference. It is perpetual motion. How is that?

Mr. WILLIS. As I understand the proposal, it is a retrospective assessment. There is no money being accrued as you go assuming that the worse would happen.

The CHAIRMAN. We discussed that and I believe you are correct.The question was where would they get the money if one of the providers went bankrupt or left town. The answer is the same again, from the employers. In a sense, we are all in the pool and it is a self-funding mechanism.

Mr. WILLIS. I guess as a regulator my concern is that I don't know in that construct who is making the solvency call. Once the benefit level has been defined——

The CHAIRMAN. There isn't one. Basically, you are just saying that the premium will be enough to provide the benefits and that is how you set it. Then there will be limits on the increase except if the premiums have to go up enough they will tax people more to put the money in.

Now I have to start talking with my hands, because I am not sure in 250 pages they got all the details. Mr. Broglie is going to write those regulations soon.

What would be your concerns in regulating a managed care plan if in fact you had a set list of benefits and a set premium and let's just say we cut the premium by 10 percent. What do you squeeze?

Mr. BROGLIE. I will address it from the experience which is similar to what we have with Medicare now where there is a fixed monthly capitated amount that we pay. The concerns that we have now, and continue to have, are what effect does whatever motivation an HMO has to make a profit have on the access to care and on the quality of care that is provided.

We have the current peer review organization system that is in place which is certainly the best tool that we have currently, but I think our view also is that the state of the art in terms of looking at performance measures and outcomes measures on the commercial side of managed care have moved much forward beyond what Medicare has. So looking at immunization rates, looking at readmission, rehospitalization, looking at actually enrollee satisfaction, are all key measures that under Medicare we want to start building into our quality assurance model for the future. I think it

would be valid measures that you would want to look at under any new model that is developed.

The CHAIRMAN. I have always felt that regulators for so long have been trained to find over utilization. You know, you must have a whole army of junk yard dogs down there in the Inspector General's office who can find over utilization. They could smell it a mile away.

Now, we are telling these same folks now you have to find underutilization and they say, wait a minute. That is our result. So you stop the rabbit in the middle of the dog race here.

Mr. BROGLIE. That has clearly been the dilemma with the peer review organization overall, which has been principally oriented to detecting underutilization—overutilization rather, on the fee-for-service side and now we are asking them to detect underutilization on the managed care side.

The CHAIRMAN. You think this can live together and you can find a way to judge that okay?

Mr. BROGLIE. Yes.

The CHAIRMAN. Well, that is good news.

I hope you guys, now that you have met, will stay in touch. You don't need me, but I would offer Mr. Willis at anytime because this is a particular interest. We are going to be charged, I think, with each State coming up with some kind of a plan. What that will be remains to be seen.

The District of Columbia has some unique circumstances. It could be that this committee will be involved in that, hopefully with the concurrence or suffer age of the District of Columbia so that we are not intruding where they would rather we didn't. But there may be some reasons—namely, money—that they would as soon have us do this.

We have a unique population. We have a unique employer here who is supposed to pony up some of the money for the underserved population, and that might work well in Cincinnati, but in Washington, D.C., we are sort of dealing with ourselves. So, I hope that you will watch as this process unfolds.

I would like to get copies at such time as I can of your regulations if they are not secret. It will give me an idea of what you plan.

Mr. WILLIS. We certainly will.

[The information follows:]

Humana Inc.
The Humana Building
500 West Main Street
P.O. Box 1438
Louisville, Kentucky
40201-1438
Telephone 502/580-1814

Ronald S. Lankford, M.D.
Senior Vice President of Medical Affairs

November 1, 1993

Humana

The Honorable Pete Stark
United States House of Representatives
Committee on the District of Columbia
Room 1309 Longworth House Office Building
Washington, DC 20515

Dear Mr. Chairman:

I am writing to follow up your request for information regarding Humana's plans for compensating sales agents in the Washington, D.C., area.

Before Humana decides how to compensate the Medicare sales agents, we will survey the market practices of competitors to establish how others compensate salespersons. Based on those results, a decision on how to compensate salespeople will be made. In order to avoid any possibility of unethical sales practices by Humana Medicare sales agents, Humana has implemented sales policies in each of its markets which provide for thorough and ongoing training and monitoring of sales agents.

Once again, Humana is excited to have the opportunity to work together with GHA to ensure the continued provision of quality health care for the District and surrounding communities.

Sincerely,

Ronald S. Lankford, M.D.
Senior Vice President

prp

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 417 and 434

Office of Inspector General

42 CFR Part 1003

[OCC–024–P]

RIN 0938–AF74

Medicare and Medicaid Programs; Requirements for Physician Incentive Plans in Prepaid Health Care Organizations

AGENCY: Health Care Financing Administration (HCFA), HHS. Office of Inspector General (OIG), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would amend the regulations governing Federally-qualified health maintenance organizations (HMOs) and competitive medical plans (CMPs) contracting with the Medicare program, and certain HMOs and health insuring organizations (HIOs) contracting with the Medicaid program, by implementing requirements in sections 4204(a) and 4731 of the Omnibus Budget Reconciliation Act of 1990 concerning physician incentive plans.

DATES: Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on February 12, 1993.

ADDRESSES: Mail comments to the following address:

Health Care Financing Administration, Department of Health and Human Services. Attention: OCC–024–P, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your written comments to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201 or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Due to staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code OCC–024–P. Written comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202–690–7890).

Organizations and individuals desiring to submit comments on the reporting requirements discussed under the section on "Collection of Information Requirements" of this preamble should direct them to the Health Care Financing Administration at one of the addresses cited above, and to the Office of Information and Regulatory Affairs, Attention: Allison Herron Edyt, Office of Management and Budget, New Executive Office Building (Room 3001), Washington, DC, 20503.

FOR FURTHER INFORMATION CONTACT:

Medicare: Parashar Patel, (202) 619–3166.

Medicaid: Ann Page, (410) 966–5364.

Office of Inspector General: Zeno St. Cyr, II, (202) 619–3270.

SUPPLEMENTARY INFORMATION:

I. Background

A. Introduction

Prepaid health care organizations, such as health maintenance organizations (HMOs), competitive medical plans (CMPs), and health insuring organizations (HIOs), are entities that provide enrollees with comprehensive, coordinated health care in a cost-efficient manner. The goal of prepaid health care delivery is to control health care costs through preventive care and care management and provide enrollees with affordable, coordinated, quality health care services. Titles XVIII and XIX of the Social Security Act (the Act) authorize contracts with prepaid health care organizations for the provision of covered health services to Medicare beneficiaries and Medicaid recipients. Such organizations may contract under either a risk-based or cost-reimbursed contract.

B. Medicare

Section 1876 of the Act authorizes the Secretary to enter into contracts with eligible organizations (HMOs that have been Federally qualified under section 1310(d) of the Public Health Service Act, and CMPs that meet the requirements of section 1876(b)(2) of the Act) to provide Medicare-covered services to beneficiaries, and specifies the requirements to be met by the organizations. Section 1876 of the Act also provides for Medicare payment at predetermined rates to eligible organizations that have entered into risk-based contracts under Medicare, or for payment of reasonable costs to eligible organizations that have entered into cost-reimbursed contracts. Implementing Federal regulations for the organization and operation of Medicare prepaid health care organizations, contract requirements, and conditions for payment are located at 42 CFR 417.400–417.694.

Risk-based organizations are paid a prospectively-determined per capita monthly payment for each Medicare beneficiary enrolled in the organization. This capitated payment is the projected actuarial equivalence of 95 percent of what Medicare would have paid for the Medicare beneficiaries if they had received services from a fee-for-service Medicare provider or supplier. Organizations paid on a risk basis are liable for any difference between the Medicare prepaid amounts and the actual costs they incur for providing services, and are therefore "at risk."

Cost-reimbursed organizations are paid monthly interim per capita payments that are based on a budget. Later, a retrospective cost settlement occurs to determine the reasonable costs actually incurred by the organization for the covered services it furnished to its Medicare enrollees.

C. Medicaid

Section 1903(m) of the Act specifies requirements that must be met for States to receive Federal financial participation (FFP) for their contracts with organizations (HMOs or HIOs) to provide specific arrays of services ("comprehensive services") on a risk basis, either directly or through arrangements. Federal implementing regulations for these contract requirements and conditions for payment are located at 42 CFR part 434.

States determine the per capita monthly rates that are to be paid to risk-based organizations. FFP is available for these payments at the matching rate applicable in the State as long as we determine that: (1) the HMO or HIO rates are actuarially sound; (2) the rates do not exceed the cost of providing the same scope of services on a fee-for-service basis, to an actuarially equivalent non-enrolled population group; and (3) the contract meets the additional requirements at 42 CFR part 434 and 45 CFR part 74.

II. Legislative History

Section 9313(c) of the Omnibus Budget Reconciliation Act of 1986 (OBRA '86), Pub. L. 99–509, enacted statutory language prohibiting hospitals and prepaid health care organizations with Medicare or Medicaid risk contracts from knowingly making incentive payments to a physician as an inducement to reduce or limit services to Medicare beneficiaries or Medicaid recipients. Under OBRA '86, parties who knowingly made or accepted such payments would have been subject to specified civil money penalties. OBRA '86 also required that the Secretary report on incentive arrangements in HMOs and CMPs.

The original implementation date for the OBRA '86 physician incentive provisions applicable to prepaid health care organizations was April 1, 1989. This date was extended by section 4016 of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Pub. L. 100–203, to April 1, 1990. Section 6207 of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Pub. L. 101–239, further extended the date to April 1, 1991. Sections 4204(a) and 4731 of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Pub. L. 101–508, repealed the prohibition of all physician incentive plans in prepaid health care organizations and enacted requirements for regulating these plans.

Specifically, section 4204(a)(1) of OBRA '90 amended section 1876(i) of the Act to list these requirements, which are that prepaid health care organizations must:

- Not operate a physician incentive plan that directly or indirectly makes specific payments to a physician or physician group as an inducement to limit or reduce medically necessary services to a specific individual enrolled with the organization;
- Disclose to HCFA their physician incentive plan arrangements in such detail as to allow HCFA to determine compliance of the arrangements with Departmental regulations; and
- In instances where a physician incentive plan places a physician or physician group at "substantial financial risk" (as defined by the Secretary) for services not provided directly, provide the physicians or physician groups with adequate and appropriate stop-loss protection (under standards determined by the Secretary), and conduct surveys of currently and previously enrolled members to assess the degree of access to services and the satisfaction with the quality of services.

Each Medicare risk and cost contract must provide that the organization may not operate a physician incentive plan that does not meet the requirements stated above. Section 4731 of OBRA '90 enacted similar provisions for the Medicaid program by amending sections 1903(m)(2)(A) and 1903(m)(5)(A) of the Act.

In addition, sections 4204(a)(2) and 4731(b)(2) of OBRA '90 added violations of the above requirements to the list of violations in sections 1876(i)(6) and 1903(m)(5) of the Act that could subject an HMO, CMP, or HIO to intermediate sanctions and civil money penalties. (On July 22, 1991, we published a Notice of Proposed Rulemaking (NPRM) that described these intermediate sanctions and civil money penalties (see 56 FR 33403). For clarity and consistency, we are republishing certain sections of the regulations that were proposed in the July 22 NPRM because we are proposing to revise those regulations to incorporate the penalty provisions of this proposed rule. See Section V. of this preamble, Revisions to the Regulations, for the specific sections that are being republished).

III. Discussion of Physician Incentive Plans

Effective utilization control that identifies both under- and over-utilization is essential for the efficient operation of prepaid health care organizations. A prepaid health care organization needs to minimize over-utilization of services not only to prevent unnecessary spending, but also to reduce the risk of unnecessary and intrusive procedures. However, a prepaid health care organization also needs to assure that all medically necessary services are provided to protect patient health and to prevent more costly care later. In addition, if a prepaid health care organization inappropriately limits care, the organization may be risking its reputation and jeopardizing its ability to compete in the marketplace. Although professional ethics, risk of malpractice liability, and market competition help ensure proper utilization of services, Medicare and Medicaid require both cost-reimbursed and risk organizations to have internal quality assurance programs, external quality review or medical audits, and other mechanisms to ensure proper delivery of health care services. Medicare and Medicaid contracts also are subject to periodic monitoring for compliance. In addition, the July 22, 1991, NPRM on civil money penalties and intermediate sanctions provides for sanctions that may be imposed when an HMO or CMP fails substantially to provide medically necessary services.

One mechanism many prepaid health care organizations use to encourage proper utilization is a financial incentive as part of a physician incentive plan. OBRA '90 defines a physician incentive plan as any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.

A review and analysis of physician incentive plans in a sample of HMOs was conducted and presented in DHHS's 1990 Report to the Congress, "Incentive Arrangements Offered by Health Maintenance Organizations and Competitive Medical Plans to Physicians." The results showed a wide variety of incentive plans. There were differences in the types of incentive payments, the distribution of incentives, the basis for determining the incentive payments, and the parties or entities the incentives affected. This wide variety of physician incentive plans make it difficult to develop regulations that will apply to all arrangements. However, despite the differences, the Report examined several broad categories of

incentive arrangements, which we have considered in developing this proposal.

Physicians in prepaid health care organizations generally receive fee-for-service payments, salary, or capitation payments (a set dollar amount per patient) for the services they provide. Financial incentives may be used with the various types of physician payments to encourage appropriate levels of referral services. Referral services are any specialty, inpatient, outpatient, or laboratory services that a physician arranges but does not provide directly. Prepaid health care organizations may hold physicians or physician groups at risk for all or a portion of the cost of referral services to that they have a financial incentive to arrange for the provision of only medically necessary services. If the physician or physician group successfully controls the levels of referral services, it may receive additional compensation (an incentive payment) from the prepaid health care organization. The incentive payment may take the form of unused capitation, a returned withhold, or a bonus payment. Each of these methods is described below.

A capitation payment is a set dollar amount per patient per month that a prepaid health care organization pays to a physician or physician group to cover a specified set of services, without regard to the actual number of services provided to each person. The capitation may cover the physician's own services, referral services, or all medical services and/or administrative costs. If patient costs exceed the capitation amount, the physician must absorb these additional costs. If costs are below the capitation, the physician may keep the additional money.

Withholds are percentages of payments or set dollar amounts that a prepaid health care organization deducts from each physician's or physician group's payment (salary, fees, or capitation). The amount withheld is set aside in pools to pay for specialty referral services and inpatient hospital services. The withhold is at risk because it may be used to pay for referral services. When referral costs exceed a prepaid health care organization's budget, part or all of the withhold may be forfeited depending on the terms of the physician's contract. If referral costs do not exceed the ceiling, part or all of the withhold may be returned to the physician or physician group. Some plans limit the amount of the risk to the withhold; others hold the physician or physician group liable for amounts beyond the amount withheld. Withholds are most often used with fee-for-service or capitation payments.

Bonuses are payments prepaid health care organizations make to a physician or physician group beyond the physician's set salary, fee-for-service payments, or capitation. Bonuses may be based on a physician's or physician group's level of referral services, or may be independent (e.g., based on the overall performance of the organization). This system is most often used for salaried physicians in staff model HMOs.

If the physician or physician group has excessive referrals (as defined by the prepaid health care organization), it may not receive any incentive funds. In addition, the prepaid health care organization may hold the physician or physician group liable for referral costs that exceed a specified threshold. The prepaid health care organization may also increase the physician's or physician group's withhold or make other changes in its incentive arrangements.

Many physician incentive plans incorporate stop-loss protection to limit the liability of the physician or physician group. Most often, the stop-loss protection limits a physician's maximum liability per patient to a specific dollar amount. For example, the organization may limit a physician's liability to $5,000 per patient from his or her withhold fund, even if actual charges are higher. In some cases, prepaid health care organizations place an aggregate limit on the liability the physician could face. Instead of limiting liability to $5,000 per patient, the organization could limit total liability for all patients to $25,000. Stop-loss protection is particularly common with capitation arrangements.

There are other variables that may affect the amount of risk or the impact of financial incentives on physicians. For example, incentive payments may be calculated according to each individual physician's performance or by a physician group's performance. The size of the physician group will also impact the incentives. Performance may be evaluated over a long or short timeframe. The number of enrollees among whom the risk is spread and the amount of total income at risk vary. In addition, the relative health status of the patients involved increases risk if the enrollees are high utilizers, or may result in lower risk if the enrollees are healthier than the average enrollee. The percentage of the physician's practice that is made up of HMO/CMP/HIO patients, as opposed to fee-for-service patients, is also pertinent.

IV. Provisions of the Physician Incentive Plan Requirements

Section 9313(c) of OBRA '86 prohibited prepaid health care organizations with Medicare or Medicaid risk contracts from knowingly making incentive payments to a physician as an inducement to reduce or limit services to Medicare beneficiaries or Medicaid recipients. However, research conducted by DHHS, subsequent to the OBRA '86 prohibition, failed to find a link between the quality of care provided under the Medicare and Medicaid programs and the structure of physician incentive plans. Similarly, other researchers have found no linkage. Despite the lack of evidence, however, various media sources have alluded to quality problems related to physician incentive payments.

Sections 4204(a) and 4731 of OBRA '90 repealed the OBRA '86 prohibition of physician incentive plans in HMOs and, instead, required that physician incentive plans be regulated. To implement this legislation for Medicare, we are proposing to impose a new contract requirement pertaining to physician incentive plans. For Medicaid, we are proposing new requirements for the granting of FFP for State Medicaid agency contracts with HMOs and HIOs. These requirements address:

- The scope of the regulation;
- Disclosure requirements;
- Criteria for the determination of substantial financial risk;
- Requirements for physician incentive plans that place physicians at substantial financial risk;
- Prohibitions on certain physician payments; and
- Penalties.

Each category of requirements is discussed individually below.

We are proposing regulations, as required by OBRA '90, and after extensive consultation with the HMO industry, which we believe establish risk thresholds that are within the bounds of current industry practices and do not unduly restrict prepaid health care organizations' operational flexibility. However, if new information regarding the influence of various elements of physician incentive plans becomes available, we will evaluate it to determine if the approach in our proposed regulations should be reconsidered.

A. Scope

These proposed regulations apply to all Medicare- or Medicaid-contracting HMOs, CMPs, and HIOs with physician incentive plans. A physician incentive

plan is any compensation arrangement between an HMO, CMP, or HIO and a physician or a physician group that may directly or indirectly have the effect of limiting or reducing services provided to enrollees.

We are proposing to apply these requirements only to physician incentive plans that base incentive payments (in whole or in part) on services provided to Medicare beneficiaries or Medicaid recipients. We are proposing to limit the scope of the requirements based on the fact that sections 4204(e)(2) and 4731 of OBRA '90 amended sections 1878 and 1903(m) of the Act, which govern Medicare and Medicaid contracts, but did not amend title XIII of the Public Health Service Act, which governs all Federally-qualified HMOs. In addition, violations of the physician incentive plan requirements may result in civil money penalties and/or intermediate sanctions which only affect a plan's payment for, or ability to enroll Medicare beneficiaries or Medicaid recipients. We believe that these facts, taken together, reflect Congressional intent that this legislation apply only to Medicare and Medicaid enrollees of prepaid health care organizations.

We considered making these proposed regulations applicable to all physician incentive arrangements in HMOs, CMPs, and HIOs (including arrangements that affected only commercial enrollees), instead of limiting it to arrangements that effect only Medicare beneficiaries and Medicaid recipients. The statutory language uses the term "individuals enrolled with the organization," which could be interpreted as all of an organization's enrollees, not just Medicare or Medicaid enrollees as proposed in this rule. We are specifically seeking comments regarding the proposed scope of the regulations.

B. Disclosure

We are proposing that an HMO, CMP or HIO disclose to HCFA (for Medicare) or to the State Medicaid agency (for Medicaid) sufficient information on physician incentive plans that affect Medicare beneficiaries or Medicaid recipients so that HCFA or States may determine whether the organization is in compliance with our proposed requirements. We are proposing that the organization submit the information—

- When it applies for a contract;
- When it applies for a service area expansion (for Medicare);
- Thirty calendar days before a change in its incentive plan; or
- Within 30 calendar days of a request by HCFA (for Medicare) or the State Medicaid agency (for Medicaid).

In addition, we are proposing a one-time disclosure requirement. This one-time disclosure would require organizations that have Medicare or Medicaid contracts in effect when this proposal is published as a final rule to submit the required information within 30 days from the effective date of the final rule.

Under our proposed disclosure requirements, an organization must submit details about any incentive plan that affects Medicare beneficiaries or Medicaid recipients to HCFA (for Medicare) or to the State Medicaid agency (for Medicaid) so that these agencies may determine whether the plan meets all other proposed requirements for physician incentive plans. All organizations must submit sufficient information to determine whether the physician incentive plan includes the prohibited arrangements proposed at § 417.479(c) and whether the plan places physicians or physician groups at substantial financial risk, as defined in proposed § 417.479(d). Organizations that hold physicians or physician groups at substantial financial risk must also submit sufficient details regarding their enrollee surveys and stop-loss protection so that HCFA (for Medicare) or the State Medicaid agency (for Medicaid) can determine that they comply with the proposed standards. If HCFA or the State Medicaid agency determines that the information the organization supplies is insufficient, the organization will be required to supply additional information within 30 days of receipt of written notification.

For Medicare contracting HMOs and CMPs, we considered reviewing the physician incentive plans only at the time of site visits, which HCFA conducts at least every 2 years. However, if a prepaid health care organization changed its physician incentive plan shortly after a site visit, we may not learn of the new compensation arrangements for 2 years. Requiring disclosure of material 30 days before a change in the physician incentive plan will ensure that we have current information. It also will facilitate quick correction of plans if an organization is found out of compliance. Because HMOs and CMPs usually do not change their incentive plans more often than annually, we do not believe that this requirement will be unduly burdensome.

We also considered not requiring submission of the physician incentive plan each time it was substantially changed. However, we believe that it is important to maintain current information on the incentive plans. We also believe that this requirement is consistent with Congressional intent that HCFA be apprised of the specifics of an organization's current physician incentive plans.

C. Substantial Financial Risk

We are proposing that a physician or physician group be considered to be at substantial financial risk if more than a specified percentage (the risk threshold) of the prepaid health care organization's total potential payments to the physician or physician group is at risk, and the risk is based on the costs of services the physician or physician group does not provide (e.g., referrals to specialists or the costs of inpatient care). For purposes of determining substantial financial risk, we are defining payments as any amounts the organization pays physicians or physician groups for services they provide, plus amounts paid for administration and controlling levels or costs of referral services. Payments do not include bonuses or other forms of compensation that are not based on referral levels (such as bonuses based solely on quality of care provided, patient satisfaction, and overall plan performance).

"At risk" means amounts that a physician or physician group may or may not receive due to factors other than the number of patients served (for capitated physicians), hours worked (for salaried physician), or services performed by the physician (for fee-for-service physicians). For example, an amount would be "at risk" if its receipt depended on the status of the pool for referral services at a specified time.

Under this proposed rule, the risk threshold that determines substantial financial risk depends on the frequency with which the health plan assesses or distributes incentive payments. The risk threshold we are proposing for substantial risk for prepaid health care organizations that assess or distribute incentive payments no more often than annually is 25 percent. The risk threshold we propose for prepaid health care organizations that assess or distribute incentive payments more often than annually is 15 percent. The term "assess" means the final calculation of the incentive payment, after which further actions by the physician or physician group will not affect the incentive payment for the period being assessed. An incentive payment assessment does not include physician profiles or updates that inform providers of their performance under an incentive plan if the period being assessed has not expired.

Because physicians and physician groups voluntarily agree to participate in financial incentive arrangements, we are proposing an outlier approach in determining substantial financial risk. The DHHS Report to the Congress identified 25 percent and 30 percent as the upper ranges of withholds used under typical circumstances. In addition, the Group Health Association of America identified the median withhold percentage as 20 percent (GHAA Research Brief, Nov. 1987). Thus, our proposed rule establishes two thresholds for determining when substantial financial risk exists: (1) 25 percent of physician or physician group payments from prepaid health care organizations that assess or distribute incentive payments no more often than annually; and (2) 15 percent when the assessment or distribution occurs more often than on an annual basis. Further, we believe that an outlier approach is appropriate since there is no evidence that conventional physician incentive plans (as discussed in DHHS's 1990 Report to the Congress) have reduced access or caused quality of care problems.

It is also important to note that physician financial incentives do not work in isolation. There are other factors, such as the threat of malpractice, quality assurance programs, peer review, and professional ethics, that work in conjunction with financial incentive plans to ensure that the appropriate level of services is provided.

1. Substantial Financial Risk When Incentive Payments are Assessed No More Than Annually

We believe that allowing possible forfeiture of up to 25 percent of a physician's or physician group's payments (as defined in § 417.479(b)) is reasonable for purposes of determining whether substantial financial risk exists when incentive payments are made no more often than annually. As stated in DHHS's Report to the Congress concerning physician incentive plans, a large proportion of physicians in fee-for-service have bad debts ranging from 10 to 20 percent (i.e., bills never collected) and many have voluntarily reduced their fees as much as 20 to 25 percent below their usual charges for selected patients. Therefore, financial incentive plans that place physicians or physician groups at risk for 25 percent of their payments from prepaid health care organizations would appear to be of the same magnitude as the reduction in payments many physicians voluntarily accept in return for increased volume and protection against bad debt, and in response to marketplace competition. (See DHHS's 1990 Report to the Congress, p. V–37.)

The DHHS Report to the Congress also noted that prepaid health care organization physicians may perceive withholds as discounts. The Report states that "In many cases there is no expectation that more than some small proportion of the withhold will ever be paid. It can be argued that in these circumstances the withholds are in effect discounts . . .". (See p. V–37) The withhold is often used to cover unanticipated expenses and is usually returned only if there are plan surpluses.

Often, prepaid health care organizations use more than one type of compensation arrangement. If more than one type of arrangement is used, we will consider all the different risk arrangements placed on physicians or physician groups to determine whether they collectively exceed the 25-percent threshold. For example, if an organization's payments included withholds and bonuses, physicians or physician groups would be at substantial financial risk if the combined withhold amounts and potential bonuses comprised more than 25 percent of their total potential payments from the plan.

We would apply the 25-percent risk threshold as follows:

a. *Withholds*—Withholds on payments to physicians or physician groups to cover referral services put them at substantial financial risk when:

- The withholds are greater than 25 percent of payments for services they provide directly and administrative costs; or
- The withholds are 25 percent or less, but the physicians or physician groups are liable for amounts over the 25-percent threshold.

This would include withholds greater than 25 percent that an organization imposes because a physician repeatedly makes referrals for services that are not medically necessary. We emphasize, however, that physicians would only be considered to be at substantial financial risk if they are at risk for services they do not provide.

Example 1: An organization's annual payment to a physician for his or her services and administration total $100,000 and the organization withholds 25 percent (or $25,000) to cover deficits in the referral or inpatient hospital pool. The organization does not hold the physician liable for referral costs that exceed the withhold. The physician is not at substantial financial risk because he or she was not at risk for more than 25 percent of payments.

Example 2: An organization's annual payments to a physician total $100,000 and the organization imposes a 20-percent withhold ($20,000) for referrals. In addition, the organization holds the physician liable for up to $5,000 of any referral costs not covered by the withhold. The physician's referrals total $35,000. That is, the physician's referral costs exceed the withhold by $15,000. However, the organization does not hold its physicians liable for amounts over 25 percent of their payments. Since the physician is not liable for amounts over 25 percent of payments ($25,000), the physician is not at substantial financial risk. Had the organization held the physician liable for all amounts over the withhold (rather than limiting such liability to $5,000 for referral costs not included in the 20-percent withhold), the physician would have lost an additional $15,000 (or $10,000 more than the 25-percent risk threshold), and would have been at "substantial financial risk" because the physician's referral costs of $35,000 exceeded 25 percent of payments.

b. Bonuses—Bonuses are of concern only when they are based on levels of referral services arranged by physicians or physician groups. We believe that bonuses that represent a considerable portion of a physician's payments from an organization potentially provide the same incentives to limit services as withholds. This is true particularly since many physicians do not expect to receive their withholds back, and perceive return of all or a portion of a withhold as a bonus. Therefore, we are proposing to treat bonuses based on levels of referral services comparable to withholds.

Thus, we propose that substantial financial risk exists if bonuses represent an additional payment greater than 33 percent of the total amount the organization would pay the physician or physician group for services provided directly and for administrative costs if the bonus was not paid. The effect of this limit is to ensure that no more than 25 percent of a physician's total potential income is contingent on the status of the referral pool at the end of a specified period.

Thus, this proposal consistently limits liability of physicians or physician groups for referral services to 25 percent of payments received from an organization. Similarly, it limits bonuses based on a physician's or physician group's referral levels. The objective is to treat compensation arrangements that are based on utilization factors similarly. To the extent that surpluses or deficits accrue in risk pools that cover referrals and

inpatient care, individuals subject to withholds and bonuses would be treated comparably in the distribution of the surpluses or deficits. Bonuses that are not based on utilization will be evaluated to determine if they meet the definition of a physician incentive plan as defined in section 4202(a) of OBRA '90.

Example: An organization's annual payments to a physician total $75,000. If the physician does not exceed utilization targets for referral and inpatient hospital services, he or she is eligible for a $25,000 bonus (33 percent of $75,000). The physician is not at substantial financial risk because the bonus did not exceed 33 percent of payments.

c. *Combination Withhold and Bonuses*—We are proposing that, if a physician incentive plan consists of both withholds and bonuses as incentives to provide appropriate utilization, the organization must ensure that no more than 25 percent of the total potential payments to the physicians or physician groups is contingent on the cost of referral services. Stated another way, the amount of the payment without the withheld amount and the bonus must be at least 75 percent of the total amount of the payments, including the withhold and bonus.

There are two methods by which an organization may determine the appropriate bonus for any given withhold. Both methods will result in the same withhold and bonus percentages. In the first method, the organization calculates the withhold's portion of 25 percent. Then, using the remaining percentage, the organization prorates the 33 percent allowed for the bonus. In the second method, the organization enters the withhold percentage in the following equation: (Withhold %) = −0.75(Bonus %) + 25%.

Example: An organization withholds 20 percent of its payments to a physician under a contract that provides for the return of withholds plus bonuses. It wants to calculate the maximum bonus. By method 1, the organization calculates that 20 percent is four-fifths of 25 percent. The organization prorates the 33 percent threshold (1/5 x 33 percent) to calculate that it cannot give more than a 6.6-percent bonus without putting the physician at substantial financial risk. By method 2, the organization puts the withhold percentage in the equation:

(20%) = −0.75(Bonus %) + 25%. This also calculates to be 6.6 percent.

d. *Capitation*—We are proposing that if an organization uses withholds or bonuses in conjunction with capitation payments that cover the costs of services provided directly and administrative costs, the requirements pertaining to withholds or bonuses would apply. If the organization uses only capitation and capitates its physicians for referral services, as well as for the services they provide directly, the physician or physician group would not be considered at "substantial financial risk" if—

- The organization specifies in the physician's or physician group's contract:
  - The maximum possible payments to be made under the capitation plan, if referral costs are low, and
  - The minimum possible payments to be made under the capitation plan, if referral costs are high; and
- The difference between the maximum and minimum payments based on referral levels is no more than 25 percent of the maximum payment.

This is consistent with the threshold for withhold and bonus incentives.

The contract could either specify actual dollar amounts or a calculation from which HCFA or States could determine that the payment would meet the test. For example, the organization could state that the maximum payment would be $100 x (the number of patients) for low referrals and the minimum payment would be $75 x (the number of patients) for high referrals. If the organization does not clearly state the physician's or physician group's risk in the contract, as expressed in maximum and minimum payments to the physician or physician group, the incentive plan would be considered as "substantial financial risk."

In examples 1 and 2, an organization capitates a physician for all medical services at $200,000 annually. This capitation includes $100,000 for the services the physician provides directly and $100,000 for referral services.

Example 1: The organization pays for all referral services if the total cost of referral services exceeds $100,000. In other words, none of the physician's capitation for his own services is at risk. In addition, the HMO allows the physician to retain up to $33,000 of the unused capitation for referral services. The contract clearly states that:

- Regardless of the level of referral services, the physician will retain the capitation of $100,000 for services provided directly.
- If referrals are lower than anticipated, the physician may retain only the first $33,000 of savings. The highest possible payments from the HMO would be $133,000.

The amount at risk would be $133,000 minus $100,000, or $33,000, which is 24.8 percent of $133,000. Therefore, the physician is not at substantial financial risk.

Example 2: The organization does not allow the physician to retain any savings from the referral account. If referrals cost less than $100,000, the physician must return the remainder of the referral account to the HMO. If the referral costs are more than $100,000, the physician may be liable for up to 25 percent of the capitation for his own services. The contract clearly states that:

- If referrals exceed $125,000, the physician will receive no less than $75,000.
- If referrals are less than $100,000, the physician will receive no more than $100,000.

Since the difference ($25,000) between the highest possible payments ($100,000) and the lowest possible payments ($75,000) is no more than 25 percent of the maximum payments, the physician is not at substantial financial risk.

Example 3: The organization pays its physicians $200/patient/month for all health care services. Of that amount, $110 of the capitation cover the services the physician provides directly and the remaining $90 cover the costs of the referral services. The health plan specifies in its physician contracts that:

- The health plan will pay stop-loss protection for the physician if referral costs average more than $100 per patient. In other words, the physician will receive at least $100/patient/month.
- Physicians may retain only up to $23/patient/month, if referral costs average less than $90/patient/month. In other words, the physician will not retain more than $133/patient/month.

The difference between the highest possible payments ($133/patient/month x the number of patients) and the lowest possible payments ($100/patient/month) is $33/patient/month. This is 24.8 percent of the highest possible payments. Therefore the physician is not at substantial financial risk.

Arrangements that do not fit the above descriptions do not automatically put physicians at substantial financial risk. However, the organization must ensure that no more than 25 percent of the total payments to the physician or physician group for services provided directly and for administrative costs are at risk based on levels of referral services. Risk may exceed the threshold if stop-loss is provided and surveys are conducted.

2. Substantial Financial Risk When Incentive Payments Are Assessed More Often Than Annually

We are proposing a lower risk threshold (15 percent) for incentive

plans that assess or distribute incentive payments more than once a year. As noted in the DHHS Report to the Congress, referenced above, and in the General Accounting Office's (GAO's) Report to the Congress, "Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care," the shorter the timeframe over which incentive arrangements assess a physician's or physician group's performance, the more influence the incentive arrangement will have. This is because physicians or physician groups have fewer patients in a short timeframe over which to spread the risk of expensive treatment than in a long timeframe. Since these types of arrangements have the potential to have a stronger influence on physician behavior, we believe that the lower risk threshold is appropriate.

We would apply the 15-percent risk threshold in the same manner as we propose to apply the 25-percent risk threshold for incentive payments. As a reminder, the risk threshold applies only if the risk is based on a physician's or physician group's levels or costs of referral services. Specifically, we would implement the 15-percent risk threshold as follows:

a. Withholds—Withholds meet the risk threshold if:

- The withhold is greater than 15 percent of payments for services the physician or physician group provides directly plus administrative costs; or
- The withhold is 15 percent of payments or less, but the physician or physician group is liable for referral amounts over the 15-percent threshold.

b. Bonuses—Bonuses would exceed the risk threshold level if they represent more than 17.6 percent of the payments for administrative costs and services provided directly. Stated another way, bonuses would exceed the risk threshold if they exceeded 15 percent of the total of the payments plus the bonus.

c. Combination Withhold and Bonuses—If a physician incentive plan uses both withholds and bonuses, the organization must ensure that the physician's or physician group's liability is no more than 15 percent of their total payments. Stated another way, the amount of the payments without the withheld amount and the bonus must be at least 85 percent of the amount of the payments including the withhold and the bonus.

The organization may determine the appropriate bonus for any given withhold by two methods. First, the organization may use the prorating method. This method is discussed earlier in this preamble in the section entitled "Substantial Financial Risk When Incentive Payments Are Assessed No More Than Annually." Second, the organization may enter the withhold percentage in the following equation:

(Withhold %) = −0.85 (Bonus %) + 15%.

d. Capitation—If an organization uses withholds or bonuses in conjunction with capitation that covers the costs of services provided directly plus administrative costs, the requirements pertaining to withholds or bonuses would apply. If the organization uses capitation for referral services, we would evaluate the arrangement as discussed earlier in this preamble under the section entitled "Substantial Financial Risk When Incentive Payments Are Assessed No More Than Annually." The only difference would be that we would consider physicians and physician groups to be at substantial financial risk once their risk exceeded 15 percent of payments, as compared to the 25-percent risk threshold.

Arrangements that are not discussed in the preceding categories are not automatically assumed to create substantial financial risk. However, the organization must ensure that no more than 15 percent of the total payments to the physician or physician group are at risk based on referral services. Otherwise, the requirements to provide stop-loss protection and conduct periodic surveys under section 1876(i)(8)(A)(ii) of the Act will apply.

3. Other Options Considered for Defining Substantial Financial Risk

In addition to the definition presented in this NPRM, we considered several other options for defining substantial financial risk. We considered alternatives that would address many factors, in addition to the frequency of risk assessment, that affect the impact of the strength of incentive arrangements. First, we considered rating each factor that could influence an incentive plan. The organization's risk threshold would be the lowest risk threshold rating among its varying factors. For example, HCFA could rate the substantial financial risk threshold for Factor A (less than 5 physicians in a group) at 15 percent and Factor B (less than 250 prepaid health care organization patients) at 10 percent. An organization with no factors would have a threshold of 25 percent. An organization with Factor A would have a threshold of 15 percent. An organization with Factor B would have a threshold of 10 percent. An organization with both Factors A and B would also have a threshold of 10 percent, because the threshold of incentive plans with multiple factors would be the threshold of the lowest individual factor (in this case, Factor B, with a 10-percent threshold).

One specific factor we considered was the size of the physician's or physician group's patient panel. The use of a percentage risk will have varying effects on small and large patient panels. The following examples demonstrate these effects. In examples a. and b., the physician's total income is $100,000; the total patient panel is 1,000 patients; the HMO pays $100/patient/year; and the risk incentive is 25 percent.

a. Individual Physician, 100 HMO patients
Physician's income from HMO = $10,000 (one-tenth of total income)
Total dollars at risk = $2,500 (25% of $10,000)
Total income at risk = 2.5%

b. Individual Physician, 1,000 HMO patients
Physician's income from HMO = $100,000 (all income is from HMO)
Total dollars at risk = $25,000
Total income at risk = 25%

In examples c. and d., there are 10 physicians in the group, each sees 1,000 patients (total panel = 10,000 patients). As above, the HMO pays $100/patient/year and the risk incentive is 25 percent. The physician group's total income is $1,000,000.

c. Physician Group, 1,000 patients
Physician group's income from HMO = $100,000 (one-tenth of total income)
Total dollars at risk = $25,000 (25% of $100,000)
Total income at risk = 2.5%

d. Physician Group, 10,000 patients
Physician group's income from HMO = $1,000,000 (all of income)
Total dollars at risk = $250,000
Total income at risk = 25%

The smaller the patient panel, the more likely the physician or physician group is to lose the entire incentive payment. However, as the examples illustrate, in small patient panels, the incentive payment is also much smaller, both in absolute terms and as a percentage of total payments.

There are two theories on how this risk will affect physicians. First, in cases where the physician is more likely to lose the entire incentive payment (i.e., small patient panels), the incentive might have a larger effect. This would be true if the physician viewed each group of patients as a line of business. Even a small incentive payment may have a large effect if the physician believed that the loss of the incentive payment would make that line of business unprofitable.

On the other hand, a large patient panel would result in a larger absolute incentive payment that represents a larger proportion of total earnings. The physician or physician group may pay more attention to a larger incentive payment, even if he/she/it has a smaller chance of losing the entire payment. Since these results are contradictory, we did not base determinations of substantial financial risk on panel size. However, we are interested in comments that address expected physician behavior in relation to the size of the patient panel.

We also considered developing a grid that would adjust the risk threshold according to the combination of factors in an incentive plan. An organization would identify its factor on the grid to determine its threshold level for substantial financial risk. Possible factors include the size of the physician pool and the services for which physicians are at risk. For example, if Factor A's threshold is 15 percent and Factor B's is 10 percent, Factors A and B could be limited to 5 percent.

With the exception of the special rule for cases in which assessments are made more frequently than annually, we decided not to adjust the threshold according to factors for several reasons. There are many factors that theoretically have the potential to influence incentive arrangements. However, no empirical research has been done in this area. There is no information available on the strength of the factors on incentive plans or on the effect of combinations of factors on incentive plans. In addition, some factors could either strengthen or weaken the incentive plans. For example, small patient panels may either increase or decrease risk. The risk may increase because the physician or physician group has fewer patients among whom to spread the risk. The risk may decrease because a small patient panel would represent a small portion of the physician's total income. Therefore, the level of services the prepaid health care organization patients used would have only a small impact on the physician's total income. The lack of information in this area made it extremely difficult to rate factors or develop grids on appropriate thresholds.

As mentioned earlier, there is no evidence that the customary physician incentive plans in prepaid health care organizations have caused lack of access or quality of care concerns. Since there is so little information available regarding the impact of various factors on physician behavior, and since existing incentive plans have not been problematic, we believe that our approach is reasonable and appropriate. As more information regarding the influence of various elements of physician incentive plans becomes available, we will evaluate it and, if appropriate, reconsider the definition of substantial financial risk.

Another option we considered was to define substantial financial risk as the median percentage plan withhold, as defined in the DHHS Report to the Congress. We would compare the amount of risk under the incentive plan to the median withhold percentage. The DHHS Report identified 15 to 20 percent as the most common median withhold percentages (see p. V–37), and the Physician Payment Review Commission (PPRC) testified before the Congress that most withholds were between 10 and 20 percent. (However, the actual risk to the physicians is often higher. Many plans use bonuses as well as withholds. These medians only account for risk from withholds. Therefore, actual risk is higher than reflected in the DHHS report or PPRC testimony.) Under this option, an exceptions process could be used to permit plans to exceed the median withhold level if the organization could show that the higher level would not place physicians at "substantial financial risk," without triggering the beneficiary survey and stop-loss protection.

We did not choose this option since it would require us to implement a case-by-case review of incentive plans that have not been shown to be problematic. In addition, the term "substantial financial risk" implies a greater than average risk, which supports our use of an outlier approach. Also, as discussed earlier in this preamble, we believe that an outlier approach is reasonable given physician perceptions of withholds. We also want to provide consistent guidelines so that organizations can determine whether their incentive plans are in compliance with our proposed requirements prior to submission for HCFA review.

We are concerned about the appropriateness of the 25-percent threshold for substantial financial risk when incentive payments are assessed no more than annually. As stated previously, we relied, in part, on the DHHS Report that indicated that fee-for-service physicians typically lose 10 to 20 percent of their income to bad debt, and plan physicians may "discount" their charges by 20 to 25 percent. Therefore, the 25 percent risk for services the physicians or physician groups provide may be reasonable. However, with respect to the first instance, we are concerned that such discounts may be factored into the plan's payments to the physician or physician group. If so, the 25-percent risk would be applied to an already discounted amount, which may not be reasonable. We are seeking specific comments regarding how physician compensation is determined in different models of HMOs and whether 25 percent is reasonable for all types of prepaid health care organizations. We also are particularly interested in public comments on our proposed definition of "substantial financial risk" and other alternatives that we considered but did not select.

D. Requirements for Physician Incentive Plans That Place Physicians at Substantial Financial Risk

1. Enrollee Surveys

As required by section 1876(i) of the Act, we are proposing that HMOs, CMPs, and HIOs that place their physicians or physician groups at substantial financial risk must conduct enrollee surveys. We are proposing that the surveys must:

- Either survey all current Medicare/Medicaid enrollees in the organization and those who have disenrolled (due to other than loss of eligibility in Medicaid) in the past 12 months, or survey a statistically valid sample of these same enrollees and disenrollees;
- Be designed, conducted, and results analyzed in accordance with commonly accepted principles of survey design and statistical analysis;
- Address enrollees'/disenrollees' satisfaction with the quality of the services provided and their degree of access to the services; and
- Be conducted at least annually.

We considered specifying additional parameters for the enrollee surveys, such as minimum sample size, minimum response rate, minimum confidence levels, or mandated survey questions. However, we recognize that there are a number of factors that are important to consider in designing an effective survey, and these factors may vary by HMO, e.g., the expected response rate to these surveys based on an organization's previous experiences in surveying enrollees and disenrollees. We further believe that these surveys will have the greatest utility if organizations can use the results of these surveys in conjunction with their other enrollee surveys and internal data collection efforts. For example, organizations may want to compare the survey results to information gathered on quality of care or disenrollment. If we are too prescriptive, organizations' use of the data collected might be limited. Also, stringent requirements

would be unnecessarily burdensome and could result in increased costs without correspondingly increased benefits.

Therefore, we are relying on HMOs to design their own surveys in accordance with commonly accepted principles of survey design and statistical analysis. HCFA (for Medicare) and States (for Medicaid) will review the survey methodology and results through the disclosure requirements and routine monitoring. We believe this affords the necessary safeguards to assure effective surveys. We are interested in comments addressing the approaches we did not take, as well as the proposed approach.

2. Stop-loss Protection

By statute, HMOs, CMPs and HIOs that place physicians or physician groups at substantial financial risk for referral services provided to Medicare beneficiaries and Medicaid recipients must provide adequate and appropriate stop-loss protection. We are proposing two levels of stop-loss protection depending on the incentive plan's risk threshold. If the risk threshold is 25 percent (the incentive plan assesses or distributes payments no more often than annually), then the stop-loss protection must protect physicians and physician groups from losses greater than 30 percent of the payments for services they provide, plus payments for administrative costs and controlling levels of referral services. If the risk threshold is 15 percent (the incentive plan assesses or distributes payments more often than annually), then the stop-loss protection must protect physicians and physician groups from losses greater than 20 percent of payments.

For capitated arrangements, it would be difficult to determine prospectively what stop-loss would cover 30 percent of payments for services the physicians or physician groups provide, plus payments for administrative costs and controlling levels of referral services. To make the stop-loss provisions for capitated arrangements comparable with the stop-loss provisions for bonus and withhold arrangements, we are proposing to permit no more than a 30-percent differential between the minimum and maximum payments a physician or physician group could receive. In other words, the difference between the maximum possible payments and the minimum possible payments could be no more than 30 percent of the maximum possible payments. If the incentive payments (or capitation) were paid more often than annually, the differential would be limited to 20 percent of the maximum payments.

These stop-loss levels are absolute limits on the physician's or physician group's liability. The stop-loss protection must cover all referral costs over 20 or 30 percent of payments, depending on how frequently incentive payments are made. Liability above the stop-loss protection level may not be transferred to physicians or physician groups in later contract years. Since this stop-loss protection limits total liability for all patients, it is referred to as an aggregate liability limit.

We decided to require more stop-loss protection for incentive plans that make payments more often than annually to make the provisions between the two risk thresholds equivalent. Under the 25-percent threshold, which applies to physician incentive plans that potentially exert less influence over physician behavior, the organization may increase the physician's or physician group's risk 5 percent beyond the risk threshold. Under our proposal, organizations with incentive plans with a 15-percent threshold would be able to increase the physician's or physician group's absolute risk beyond the risk threshold to the same extent, 5 percent. The organization can either provide or buy the stop-loss protection, or the physician or physician group can obtain the protection.

Many prepaid health care organizations design their stop-loss arrangements to limit liability for individual patients to a maximum dollar amount. This helps to protect against catastrophic cases. We considered placing limits on a physician or physician group's maximum liability per patient instead of using a maximum aggregate liability limit. However, without an aggregate limit on the physician's liability, a physician or physician group could ultimately receive zero net payments from the prepaid health care organizations.

Although individual stop-loss protection helps protect physicians and physician groups, a maximum limit on aggregate liability is necessary. Even if a physician group's liability is limited to no more than $10,000 per patient, if the physician group earns a good reputation for its treatment of AIDS patients, for example, it could easily be liable for all of its payments if increasing numbers of AIDs patients comprise the Medicare and Medicaid portion of the patient panel. Conceivably, the physician group would be forced to leave the prepaid health care organization, declare bankruptcy, or greatly restrict its treatment of all patients. Since it was Congressional intent to protect physicians and physician groups from unlimited liability, we believe that an aggregate limit is appropriate.

We also considered stop-loss standards that would permit more risk sharing between the prepaid health care organization and the physician or physician group. For example, we considered stop-loss protection that would cover 80 percent of referral costs when they exceeded 30 percent (or 20 percent) of payments. This would cause the physician or physician group to be liable for the remaining 20 percent of referral costs. However, we are proposing 100-percent coverage of referral costs over 30 percent (or 20 percent) of payments because even a limited risk-sharing arrangement could potentially cause a physician or physician group to be liable for large amounts of money. Under this arrangement, however, the organization could arrange any risk-sharing or stop-loss arrangements it finds effective for liability amounts less than 30 percent (or 20 percent) of payments.

We considered requiring the organization to provide the stop-loss insurance instead of permitting the physician or physician group to obtain the protection themselves. However, some physician groups prefer to obtain their own stop-loss protection rather than accepting the protection the organization offers (often the organization lowers capitation rates or charges physicians or physician groups for stop-loss protection). We wanted to retain this flexibility for physicians and physician groups. Since the legislation requires the organization to provide the stop-loss protection, we are requiring the organization to pay the cost of the portion of stop-loss protection that covers its enrollees in the physician incentive plan, or increase the amount of stop-loss protection to account for the physician's cost for stop-loss.

In cases where protection that meets the proposed standards is not available through the market, the organization would have to provide it directly. Regardless of how the stop-loss protection is provided, the organization must assure HCFA or the States that all physicians or physician groups that provide services to Medicare beneficiaries and Medicaid recipients and are at "substantial financial risk" for referral services have stop-loss protection that meets the regulatory requirements.

E. Prohibited Physician Payments

As required by OBRA '90, these regulations provide that physician incentive plans may operate only if no specific payment is made directly or

indirectly under the plan as an inducement to reduce or limit medically necessary services provided to a specific enrollee. This provision specifically prohibits bonuses or other payments to a physician or physician group as an inducement to limit or reduce medically necessary services for any individual patient. The proposed rule clarifies that indirect payments include items of money value, such as waivers of debt, or stock or equity in the organization. For example, an organization would be prohibited from paying a physician a $100 bonus or providing $100 of stock for each individual enrollee released from a hospital after delivery of a child in two days versus three days, if inpatient services were medically necessary on day three.

We considered interpreting "specific payments made indirectly as an inducement" as any payments that had the indirect effect of reducing medically necessary services. However, the statutory provision specifies that "no specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services . . .". The use of "indirectly" in the statute refers to the method by which payment is made, not to the effect of the payment. Therefore, we believe that the statutory language prohibits an alternative interpretation of the provision.

This proposed provision would not prohibit all bonuses based on utilization. For example, bonuses that are based on general utilization levels (i.e., bonuses determined by aggregate patient utilization) would be permitted.

F. Enforcement

Organizations that do not comply with these requirements may be subject to certain penalties. Determinations of non-compliance may result in civil money penalties, intermediate sanctions, and/or contract termination (for Medicare) or withholding of FFP (for Medicaid). The civil money penalties would be limited to $25,000 for each determination of non-compliance. Under the intermediate sanctions provision, HCFA (for Medicare) could suspend the enrollment of individuals into non-compliant plans and HCFA (for Medicare) or the State (for Medicaid) could suspend payment for new enrollees until it is satisfied that the basis for the determination is not likely to recur. The process for applying civil money penalties and intermediate sanctions would be the same process as that proposed in the July 22, 1991, NPRM discussed earlier in this preamble.

We are proposing that States determine compliance with these provisions for organizations contracting with Medicaid. Unlike Medicare, the Medicaid program is administered by State governments, pursuant to the Federal statutory and regulatory requirements, and a Medicaid State plan approved by HCFA. State governments are thus responsible for contracting with HMOs and other prepaid health care organizations, as well as for monitoring such contracts. In the case of Medicaid contracts, therefore, we believe that States are in the best position to monitor adherence to these specified requirements for physician incentive plans, to make determinations as to whether a violation has occurred, and to recommend intermediate sanctions based upon the nature of the violation. We are, therefore, proposing to rely upon States to perform the same monitoring functions in the Medicaid program that HCFA will perform in the Medicare program.

V. Revisions to the Regulations

Because these regulations would amend the civil money penalties and intermediate sanctions proposed in the July 22, 1991, NPRM discussed earlier in this preamble, we are republishing portions of that NPRM in these proposed regulations. Specifically, we are republishing proposed 42 CFR 417.495, which provides the requirements for imposing sanctions against eligible HMOs and CMPs, and proposed 42 CFR 434.67, which provides the requirements for imposing sanctions against HMOs with comprehensive risk contracts. We also are republishing 42 CFR 1003.100 through 1003.103 and 42 CFR 1003.106, which pertain to civil money penalties and assessments, incorporating the revisions proposed in the July 22, 1991, NPRM. While we are republishing the aforementioned sections of the regulations that were proposed in the July 22, 1991, NPRM for clarity, we request that public comments be limited to penalties and sanctions relating to physician incentive plans proposed in this NPRM.

To incorporate the policies and implement the statutory provisions described in this preamble, we propose to make the following revisions to title 42 of the regulations:

- In part 417, Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans, we would add to subpart L a new § 417.479, Requirements for physician incentive plans, to specify the requirements eligible organizations that use physician incentive plans must meet.
- We would add a new paragraph (e)(7) to proposed § 417.495, Sanctions against the organization, to specify an additional basis upon which sanctions may be applied against organizations.
- In part 434, Contracts, subpart D, we would amend § 434.44(e)(1) to incorporate these requirements into regulations governing certain HIOs that arrange for comprehensive services on a risk basis.
- In subpart E, we would add a new paragraph (e)(5) to proposed § 434.67, Sanctions against HMOs with comprehensive risk contracts, to specify an additional basis upon which sanctions may be applied against organizations.
- In subpart F, we would revise § 434.70 to condition FFP in State contracts with HMOs and certain HIOs on both the State and its HMO or HIO contractor meeting certain specified requirements for physician incentive plans.
- In part 1003, Civil Money Penalties and Assessments, we would revise § 1003.101 to include a definition for "physician incentive plan."
- We would revise § 1003.103 to add a new paragraph (e)(1)(vi) to specify an additional basis upon which the Office of the Inspector General may impose civil money penalties on organizations.
- We would revise §§ 1003.100, 1003.102, and 1003.106 to reference the physician incentive plan requirements, as appropriate.

VI. Collection of Information Requirements

Proposed regulations at § 417.479 (g) and (h), and § 434.70 (a)(2) and (b)(3) contain information collection or recordkeeping requirements or both that are subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.). Specifically, § 417.479(g) requires organizations that operate incentive plans that place physicians or physician groups at substantial financial risk to conduct enrollee surveys subject to conditions described in § 417.479(g)(1), and §§ 417.479(h) and 434.70(a)(2) concern the disclosure of information to HCFA or States concerning an HMO or CMP's physician incentive plan and the conducting of annual enrollee surveys. The respondents who will provide the information include HMOs, CMPs and HIOs that contract with the Medicare program or States and have physician incentive plans. Additionally, § 434.70(b)(3) requires States to obtain from certain HMO or HIO contractors

proof that the contractor meet the proposed requirements for physician incentive plans.

The public reporting burden for these information collections is estimated to be 50 hours per organization for survey requirements, 4 hours per organization for disclosure requirements, and 1 hour per State for each physician incentive plan for which proof of compliance is required.

A notice will be published in the Federal Register after approval is obtained. Organizations and individuals desiring to submit comments on the information collection and recordkeeping requirements should direct them to the OMB official whose name appears in the "ADDRESSES" section of this preamble.

VII. Response to Comments

Because of the large volume of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, we will consider all comments that we receive by the date and time specified in the "DATES" section of this preamble, and if we proceed with the final rule, we will respond to the comments in the preamble to the final rule.

VIII. Regulatory Impact Statement

Executive Order 12291 (E.O. 12291) requires us to prepare and publish an initial regulatory impact analysis for any proposed regulations that are likely to meet criteria for a "major rule." A major rule is one that would result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or any geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In addition, we generally prepare and publish an initial regulatory flexibility analysis for proposed regulations consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601–602), unless the Secretary certifies that the regulations would not have a significant impact on a substantial number of small entities. For purposes of the RFA, we treat all HMOs, CMPs, and HIOs as small entities.

These proposed regulations would amend the regulations governing certain Federally qualified HMOs and CMPs contracting with the Medicare program, and certain HMOs and HIOs contracting with the Medicaid program, by adding requirements for physician incentive plans that these entities must meet. We expect these proposed rules to affect approximately 300 HMOs, CMPs, and HIOs. However, we expect few incentive plans will require changes to comply with the regulations. In addition, since we expect that most current incentive plans already comply with the proposed regulations, we believe that we will rarely need to impose sanctions or penalties. Therefore, we expect very little costs to organizations. Likewise, we expect few additional surveys and additional stop-loss protection, with the result being that costs are incurred by only a small number of facilities.

For these reasons, we have determined that a regulatory impact analysis is not required. Further, we have determined, and the Secretary certifies, that these proposed rules would not have a significant economic impact on the operations of a substantial number of small rural hospitals. We, therefore, have not prepared a regulatory flexibility analysis.

Section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a metropolitan statistical area and has fewer than 50 beds. These proposed regulations affect HMOs, CMPs, and HIOs. Consequently, we have determined, and the Secretary certifies, that these proposed regulations would not have a significant economic impact on the operations of a substantial number of small rural hospitals and, therefore, have not prepared a rural impact statement.

List of Subjects

42 CFR Part 417

Administrative practice and procedure, Health maintenance organization (HMO), Medicare, Reporting and recordkeeping requirements.

42 CFR Part 434

Grant programs—Health, Health maintenance organization (HMO), Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 1003

Administrative practice and procedure, Fraud; Grant programs—Health; Health facilities; Health profession; Maternal and child health; Medicaid; Medicare; Penalties.

Title 42—Public Health

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

I. Chapter IV of title 42 would be amended as set forth below:

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

A. Part 417 is amended as follows:

1. The authority citation for part 417 continues to read as follows:

Authority: Secs. 1102, 1853(a)(1)(A), 1861(s)(2)(H), 1866(a), 1871, 1874, and 1876 of the Social Security Act (42 U.S.C. 1302, 1395l(a)(1)(A), 1395x(s)(2)(H), 1395cc(a), 1395hh, 1395kk, and 1395mm); sec. 114(c) of Pub. L. 97–248 (42 U.S.C. 1395mm note); 31 U.S.C. 9701; and secs. 215 and 1301 through 1318 of the Public Health Service Act (42 U.S.C. 216 and 300e through 300e–17), unless otherwise noted.

2. A new § 417.479 is added to read as follows:

§ 417.479 Requirements for physician incentive plans.

(a) *Applicability.* The requirements in this section apply to physician incentive plans between eligible organizations and individual physicians or physician groups with whom they contract to provide medical services to enrollees. These requirements do not apply to financial incentive arrangements between physician groups (as defined in paragraph (b) of this section) and individual physicians who are members of such groups. These requirements only apply to physician incentive plans that base compensation (in whole or in part) on the use or cost of services provided to Medicare beneficiaries or Medicaid recipients.

(b) *Definitions.* For purposes of this section:

Bonus means a payment an organization makes to a physician or physician group beyond any salary, fee-for-service payments, capitation, or returned withhold.

Capitation means a set dollar payment per patient per unit time (usually per month) that an organization pays a physician or physician group to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include the physician's own services, referral services, or all medical services.

Payments means any amounts the organization pays physicians or

physician groups for services they provide directly, plus amounts paid for administration and amounts paid (in whole or in part) based on levels and costs of referral services (such as withhold amounts, bonuses based on referral levels, and any other compensation to the physician or physician group to influence the use of referral services). Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care provided, patient satisfaction, and participation on committees) are not considered peyments for purposes of this subpart.

Physicion group means a partnership, essociation, corporation, individual practice essociation, or other group that distributes income from practice among members according to a prearranged plan unrelated to the members' referral levels.

Physicion incentive plon means any compensation arrangement between an organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided to Medicare beneficiaries or Medicaid recipients enrolled in the organization.

Referral services means any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges, but does not provide directly.

Risk threshold means the maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk.

Withhold means a percentage of peyments or set dollar amounts that an organization deducts from a physician's service fee, capitation, or salary payment, and which may or may not be returned to the physician, depending on specific predetermined factors.

(c) *Prohibited physicion poyments.* Organizations may operate physician incentive plans only if no specific payment of any kind is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided to an individual enrollee. Indirect payments include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

(d) *Generol Rule: Determinotion of substontiol finonciol risk.* Substantial financial risk occurs when the incentive arrangements place the physician or physician group at risk for amounts beyond the risk threshold, if the risk is based on the levels or costs of referral services. Amounts at risk based solely on factors other than a physician's or physician group's referral levels do not contribute to the determination of substantial financial risk. The risk thresholds are:

(1) 25 percent if the incentive plan distributes or assesses incentive payments no more often than annually; and

(2) 15 percent if the incentive plan distributes or assesses incentive peyments more often than annually.

(e) *Arrangements thot couse substontiol finonciol risk when the risk threshold is 25 percent.* The following physician incentive plans cause substantial financial risk if risk is based (in whole or in part) on levels or costs of referral services, and incentive payments are distributed and/or assessed no more than annually:

(1) Withholds greater than 25 percent of payments;

(2) Withholds less then 25 percent of peyments if the physician or physician group is potentially liable for amounts exceeding 25 percent of payments;

(3) Bonuses thet are greater than 33 percent of payments minus the bonus;

(4) Withholds plus bonuses when the withholds plus bonuses equal more than 25 percent of peyments. The threshold bonus percentage for a particular withhold percentage mey be calculated using the formula—

Withhold %=−0.75(Boous %)+25%;

(5) Capitation arrangements, if—

(i) The difference between the maximum possible payments and minimum possible payments is more than 25 percent of the maximum possible payments; or

(ii) The maximum and minimum possible peyments are not clearly explained in the physician's or physician group's contract; and

(6) Any other incentive arrangements that heve the potential to hold a physician or physician group liable for more than 25 percent of peyments.

(f) *Arrangements thot couse substontiol finonciol risk when the risk threshold is 15 percent.* The following physician incentive plans cause substantiel financiel risk if risk is based (in whole or in part) on levels or costs of referral services, and incentive peyments are distributed and/or assessed more often than annually:

(1) Withholds greater than 15 percent of peyments;

(2) Withholds less than 15 percent of payments if the physician or physician group is potentially liable for amounts exceeding 15 percent of payments;

(3) Bonuses that are greater than 17.6 percent of peyments minus the bonus;

(4) Withholds plus bonuses when the withholds plus bonuses equals more than 15 percent of peyments for services they provided directly. The threshold bonus percentage mey be calculated with the formula—

Withhold %=−0.85(Bonus %)+15%;

(5) Capitation arrangements, if—

(i) The difference between the maximum possible peyments and minimum possible payments is more than 25 percent of the maximum possible peyments; or

(ii) The maximum and minimum possible peyments are not clearly explained in the physician's or physician group's contract; and

(6) Any other incentive arrangements that have the potential to hold a physician or physician group liable for more than 15 percent of peyments.

(g) *Requirements for physicion incentive plans thot place physicions at substontiol finonciol risk.* Organizations that operate incentive plans that place physicians or physician groups at substantial financial risk must do the following:

(1) Conduct enrollee surveys. These surveys must—

(i) Include either all current Medicare/Medicaid enrollees in the organization and those who have disenrolled (due to other than loss of eligibility in Medicaid) in the past 12 months, or a sample of these same enrollees and disenrollees;

(ii) Be designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis;

(iii) Address enrollees/disenrollees satisfaction with the quality of the services provided and their degree of access to the services; and

(iv) Be conducted at least annually.

(2) Ensure that all physicians and physician groups at substantial financial risk have stop-loss protection in accordance with the following requirements:

(i) If the risk threshold is 25 percent, the stop-loss protection must cover the costs of referral services when the costs (beyond allocated amounts) exceed 30 percent of peyments.

(ii) If the risk threshold is 15 percent, the stop-loss protection must cover the costs of referral services when the costs (beyond allocated amounts) exceed 20 percent of payments.

(iii) The organization may provide the stop-loss protection directly or purchase the stop-loss protection, or the physician or physician group may purchase the stop-loss protection. If the physician or physician group purchases the stop-loss protection, the organization must pay the portion of the premium that covers its enrollees or

reduce the level at which the stop-loss protection applies by the cost of the stop-loss.

(h) *Disclosure requirements for organizations with physician incentive plans.* All organizations must provide to HCFA information concerning its physician incentive plans as required or requested. The information must contain sufficient descriptive information to enable HCFA to determine whether the plan complies with the requirements specified in this section. Organizations must provide this information to HCFA—

(1) Upon application for a contract;

(2) Upon application for a service area expansion;

(3) 30 days before a change in its incentive plan;

(4) Within 30 days of a request by HCFA; and

(5) For organizations with a contract on [insert effective date of final rule], by [insert 30 days from effective date of final rule].

(i) *Sanctions against the organization.* HCFA may apply intermediate sanctions, or the Office of Inspector General may apply civil money penalties described at § 417.495, if HCFA determines that an eligible organization fails to comply with the requirements of this section.

3. A new § 417.495 is added to read as follows:

§ 417.495 Sanctions against the organization.

(a) *Basis for application of sanctions.* HCFA may apply intermediate sanctions specified in paragraph (d) of this section, as an alternative to termination, if HCFA determines that an organization with a contract under this part—

(1) Fails substantially to provide medically necessary items and services that are required to be provided to an individual covered under the contract, and the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(2) Imposes premiums on individuals enrolled under this part in excess of premiums permitted;

(3) Acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

(4) Engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) with the organization by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

(5) Misrepresents or falsifies information that is furnished—

(i) To HCFA under this part;

(ii) To an individual or to any other entity under this part;

(6) Fails to comply with the requirements of section 1878(g)(6)(A) of the Act relating to the prompt payment of claims;

(7) Fails to comply with the requirements of § 417.479(c) through (h) relating to physician incentive plans;

(8) Fails to meet the requirement in section 1876(f)(1) of the Act that not more than 50 percent of the organization's enrollment may be Medicare beneficiaries and Medicaid recipients; or

(9) Has a Medicare risk contract and—

(i) Employs or contracts with individuals or entities excluded from participation in Medicare under sections 1128 or 1128A of the Act for the provision of health care, utilization review, medical social work, or administrative services; or

(ii) Employs or contracts with any entity for the provision of such services (directly or indirectly) through an excluded individual or entity.

(b) *Notice of intermediate sanction.* Prior to applying the sanctions specified in paragraph (d) of this section, HCFA will send a written notice to the organization stating the nature and basis of the proposed sanction. A copy of the notice (other than a notice for the violation described in paragraph (a)(8) of this section) will be forwarded to the Office of Inspector General at the same time that it is sent to the organization. HCFA will allow the organization 15 days after the date it receives the notice to provide evidence that the organization has not committed an act or failed to comply with a requirement described in paragraph (a) of this section, as applicable.

(c) *Informal reconsiderotion.* If the organization submits a timely response to HCFA's notice of intermediate sanction, HCFA will conduct an informal reconsideration that includes:

(1) Review of the evidence by a HCFA official who did not participate in the initial decision to impose a sanction; and

(2) If the decision to impose a sanction is affirmed on review, forwarding to the organization a concise written decision setting forth the factual and legal basis for the decision.

(d) *Intermediate sanctions.* If HCFA determines that an organization has committed a violation described in paragraph (a) of this section and this determination is affirmed on review in the event the organization timely contests the determination under paragraph (b) of this section, HCFA may—

(1) Require the organization to suspend new applications for enrollment from Medicare beneficiaries after the effective date in paragraph (e)(1) of this section; or

(2) Suspend payments to the organization for any individuals who apply for enrollment after the effective date in paragraph (e)(1) of this section.

(e) *Effective date and duration of intermediate sanctions.* (1) Intermediate sanctions will be made effective 15 days after the date that the organization is notified of the decision to impose the sanctions, unless the organization timely seeks reconsideration under paragraph (c) of this section, in which case the intermediate sanction generally will be effective on the date the organization is notified of HCFA's decision under paragraph (c)(2) of this section.

(2) If HCFA determines that the organization's conduct poses a serious threat to an enrollees' health and safety, the intermediate sanction may be made effective on a date prior to issuance of HCFA's decision under paragraph (c)(2) of this section.

(3) The sanction will remain in effect until HCFA notifies the organization that HCFA is satisfied that the basis for applying the sanction has been corrected and is not likely to recur.

(f) *Termination by HCFA.* As an alternative to the sanctions described in paragraph (d) of this section, HCFA may decline to renew an organization's contract in accordance with § 417.492(b), or terminate its contract in accordance with § 417.494(b).

(g) *Civil money penalties.* If HCFA determines that an organization has committed an act or failed to comply with a requirement described in paragraph (a) of this section (with the exception of the violation described in paragraph (a)(8) of this section), HCFA will convey such determination to the Office of Inspector General. In accordance with the provisions of 42 CFR part 1003, the OIG may impose civil money penalties on the organization in addition to or in lieu of the intermediate sanctions imposed by HCFA.

PART 434—CONTRACTS

B. Part 434 is amended as follows:

1. The authority citation for part 434 is revised to read as follows:

Authority: Secs. 1102, 1902(a)(4), 1902(p)(2), and 1903(m) of the Social Security Act (42 U.S.C. 1302, 1396(a)(4), 1396a(p)(2), and 1396b).

2. In subpart D, § 434.44(a)(1) is revised to read as follows:

§ 434.44 Special rules for certain health insuring organizations.

(a) A health insuring organization that first enrolls patients on or after January 1, 1988, and arranges with other providers (through subcontract, or through other arrangements) for the delivery of services (as described in § 434.21(b)) to Medicaid enrollees on a prepaid capitation risk basis is—

(1) Subject to the general requirements set forth in § 434.20(d) concerning services that may be covered and § 434.20(e) which set forth the requirements for all contracts, the additional requirements set forth in §§ 434.21 through 434.38 and the Medicaid agency responsibilities specified in subpart E of this part; and

* * * * *

3. In subpart E, a new § 434.67 is added to read as follows:

§ 434.67 Sanctions against HMOs with comprehensive risk contracts.

(a) *Basis for application of sanctions.* The agency may recommend that the intermediate sanction specified in paragraph (e) of this section be imposed if the agency determines that an HMO with a comprehensive risk contract—

(1) Fails substantially to provide medically necessary items and services that are required under law or under the contract to be provided to an individual covered under the contract, and the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(2) Imposes premiums on individuals covered under the contract in excess of premiums permitted;

(3) Engages in any practice that discriminates among individuals on the basis of their health status or requirements for health care services, including expulsion or refusal to re-enroll an individual, or any practice that could reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by section 1903(m) of the Act) by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

(4) Misrepresents or falsifies information that is furnished—

(i) To HCFA or the State agency under section 1903(m) of the Act; or

(ii) To an individual or to any other entity under section 1903(m); or

(5) Fails to comply with the requirements of § 417.479 (c) through (g) of this chapter relating to physician incentive plans, or fails to submit to the State Medicaid agency its physician incentive plans as required or requested in § 434.70.

(b) *Effect of an agency determination.* (1) When the agency determines that an HMO with a comprehensive risk contract has committed one of the violations identified in paragraph (a) of this section, the agency must forward this determination to HCFA. This determination becomes HCFA's determination for purposes of section 1903(m)(5)(A) of the Act, if HCFA does not reverse or modify the determination within 15 days.

(2) When the agency decides to recommend imposition of the intermediate sanction specified in paragraph (e) of this section, this recommendation becomes HCFA's decision, for purposes of section 1903(m)(5)(B)(ii) of the Act, if HCFA does not reject this recommendation within 15 days.

(c) *Notice of intermediate sanction.* If a determination to impose intermediate sanctions becomes HCFA's determination in accordance with paragraph (b)(2) of this section, the agency must send a written notice to the HMO stating the nature and basis of the proposed sanction. A copy of the notice will be forwarded to the OIG at the same time that it is sent to the organization. The agency will allow the HMO 15 days after the date it receives the notice to provide evidence that the HMO has not committed an act or failed to comply with a requirement described in paragraph (a) of this section, as applicable.

(d) *Informal reconsideration.* (1) If the HMO submits a timely response to the agency's notice of intermediate sanction, the agency will conduct an informal reconsideration that includes—

(i) Review of the evidence by an agency official who did not participate in the initial recommendation to impose a sanction; and

(ii) A concise written decision setting forth the factual and legal basis for the decision.

(2) The agency decision under paragraph (d)(1)(ii) of this section will be forwarded to HCFA and will become HCFA's decision if HCFA does not reverse or modify the decision within 15 days. The agency will send the HMO a copy of HCFA's decision under this section.

(e) *Intermediate sanction.* If a HCFA determination that an HMO has committed a violation described in paragraph (a) of this section is affirmed on review under paragraph (d) of this section, or is not timely contested by the HMO under paragraph (c) of this section, HCFA, based upon the recommendation of the agency, may deny payment for new enrollees of the HMO pursuant to section 1903(m)(5)(B)(ii) of the Act. Under §§ 434.22 and 434.42, this denial of payment by HCFA for new enrollees automatically results in a denial of agency payments to the HMO for the same enrollees. A "new enrollee" is defined as an enrollee that applies for enrollment after the effective date in paragraph (f)(1) of this section.

(f) *Effective date and duration of intermediate sanction.* (1) Unless an HMO timely seeks a reconsideration in accordance with paragraph (d) of this section or HCFA determines the violation poses a serious threat to enrollees' health or safety, intermediate sanctions will be made effective 15 days after the date that the HMO is notified of the HCFA decision to impose the sanction in accordance with the procedures specified in paragraph (c) of this section. If the HMO seeks reconsideration under paragraph (d) of this section, the intermediate sanction generally will be effective on the date the organization is notified of HCFA's decision under paragraph (d)(1)(ii) of this section.

(2) If HCFA, in consultation with the agency, determines that the HMO's conduct poses a serious threat to an enrollee's health and safety, the intermediate sanction may be made effective on a date prior to issuance of the decision under paragraph (d)(1)(ii) of this section.

(3) The sanction will remain in effect until HCFA, in consultation with the agency, is satisfied that the basis for applying the sanction has been corrected and is not likely to recur.

(g) *Civil money penalties.* If a determination that an organization has committed a violation under paragraph (a) of this section becomes HCFA's determination under paragraph (b)(1) of this section, HCFA will convey such determination to the Office of Inspector General. In accordance with the provisions of 42 CFR Part 1003, the OIG may impose civil money penalties on the organization in addition to or in lieu of the intermediate sanctions imposed under this section.

(h) *Performance of functions.* HCFA retains the right to independently perform the functions assigned to the agency in paragraphs (a) through (f) of this section.

(i) *State plan requirements.* The State plan must include a plan to monitor for violations specified in paragraph (a) of this section and for implementing the provisions of this section.

4. In Subpart F, § 434.70 is revised to read as follows:

§ 434.70 Condition for FFP.

(a) FFP is available in expenditures for payments to contractors only for the periods that—

(1) The contract—

(i) Meets the requirements of this part;

(ii) Meets the appropriate requirements of 45 CFR Part 74; and

(iii) Is in effect; and

(2) The HMO or HIO contractor complies with the requirements specified in § 417.479 (c) through (g) of this chapter, and has supplied sufficient information on its physician incentive plan to the State Medicaid agency to enable the State to determine whether the plan complies with such requirements. The HMO or HIO must supply this information to the State Medicaid agencies—

(i) Upon application for a contract;

(ii) Within 30 days of a change in its incentive plan;

(iii) Within 30 days of a request by the State or HCFA; and

(iv) For organizations with a contract on December 14, 1992 of final rule, by January 13, 1992 of final rule.

(b) HCFA may withhold FFP for any period during which—

(1) The State fails to meet the State plan requirements of this part;

(2) Either party to a contract substantially fails to carry out the terms of the contract; or

(3) The State fails to obtain from each HMO or HIO contractor proof that it meets the requirements for physician incentive plans specified in § 417.479 (c) through (g) of this chapter.

CHAPTER V—OFFICE OF INSPECTOR GENERAL—HEALTH CARE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

II. Chapter V of title 42 would be amended as set forth below:

PART 1003—CIVIL MONEY PENALTIES, ASSESSMENTS AND EXCLUSIONS

A. Part 1003 is amended as follows:

1. The authority citation for part 1003 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1320a–7, 1320a–7a, 1320b–10, 1395mm, 1395ss(d), 1395u(j), 1395u(k), 1396b(m), 11131(c) and 11137(b)(2).

2. Section 1003.100 is amended by revising paragraph (a); republishing paragraph (b)(1) introductory text revising paragraphs (b)(1)(iv) and (b)(1)(v) and adding a new paragraph (b)(1)(vi) to read as follows:

§ 1003.100 Basis and purpose.

(a) *Basis.* This part implements sections 1128, 1128(c), 1128A, 1140, 1842(j), 1842(k), 1876(i)(6), 1882(d), and 1903(m)(5) of the Social Security Act and sections 421(c) and 427(b)(2) of Pub. L. 99–660 (42 U.S.C. 1320a–7, 1320a–7(c), 1320a–7a, 1320b–10, 1395mm, 1395ss(d), 1395u(j), 1395u(k), 1396b(m)), 11131(c) and 11137(b)(2)).

(b) *Purpose.* * * *

(1) Provides for the imposition of civil money penalties and, as applicable, assessments against persons who—

* * * * *

(iv) Fail to report information concerning medical malpractice payments or who improperly disclose, use, or permit access to information reported under part B of title IV of Pub. L. 99–660, and regulations specified in 45 CFR part 60;

(v) Misuse certain Medicare and Social Security program words, letters, symbols, and emblems; or

(vi) Substantially fail to provide an enrollee with required medically necessary items and services, or who engage in certain marketing, enrollment, reporting, claims payment, employment, or contracting abuses, or who do not meet the requirements for physician incentive plans for Medicaid specified in § 417.479 (c) through (g) of this title.

* * * * *

3. Section 1003.101 is amended by adding, in alphabetical order, definitions for the terms *adverse effect, contracting organization, enrollee,* and *physician incentive plan* to read as follows:

§ 1003.101 Definitions.

* * * * *

Adverse effect means medical care has not been provided and the failure to provide such necessary medical care has presented an imminent danger to the health, safety, or well-being of the patient, or has placed the patient unnecessarily in a high-risk situation.

* * * * *

Contracting organization means a public or private entity, inclusive of a health maintenance organization (HMO), competitive medical plan (CMP), or health insuring organization (HIO) which meets the requirements of section 1876(b) or is subject to the requirements in section 1903(m)(2)(A) of the Social Security Act, and which has contracted with the Department or a State to provide medical items and services to Medicare beneficiaries or Medicaid recipients.

Enrollee means an individual who is eligible for Medicare or Medicaid, and who enters into an agreement to receive medical items and services from a contracting organization that contracts with the Department under titles XVIII or XIX of the Social Security Act.

* * * * *

Physician incentive plan means any compensation arrangement between a contracting organization and a physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to enrollees in the organization.

* * * * *

4. In § 1003.102, paragraph (b) introductory text is republished and a new paragraph (b)(8) is added, to read as follows:

§ 1003.102 Basis for civil money penalties and assessments.

* * * * *

(b) The OIG may impose a penalty, and where authorized, an assessment against any person (including an insurance company in the case of paragraphs (b)(5) and (b)(6) of this section) whom it determines in accordance with this part—

* * * * *

(8) Is a contracting organization that HCFA determines has committed an act or failed to comply with the requirements set forth in §§ 417.495(a), 434.67(a), and 434.80(c) of this title.

* * * * *

5. Section 1003.103 is amended by revising paragraph (a) and adding new paragraph (e), to read as follows:

§ 1003.103 Amount of penalty.

(a) Except as provided in paragraphs (b), (c), (d), and (e) of this section, the OIG may impose a penalty of not more than $2,000 for each item or service that is subject to a determination under § 1003.102.

* * * * *

(e)(1) The OIG may, in addition to or in lieu of other remedies available under law, impose a penalty of up to $25,000 for each determination by HCFA that a contracting organization has:

(i) Failed substantially to provide an enrollee with required medically necessary items and services, if the failure adversely affects (or has the likelihood of adversely affecting) the enrollee;

(ii) Imposed premiums on enrollees in excess of amounts permitted under section 1876 or title XIX of the Act;

(iii) Acted to expel or to refuse to re-enroll a Medicare beneficiary in violation of the provisions of section 1876 of the Act, and for reasons other than the beneficiary's health status or requirements for health care services;

(iv) Misrepresented or falsified information furnished to an individual or any other entity under section 1876 or 1903(m) of the Act;

(v) Failed to comply with the requirements of section 1876(g)(6)(A) of

the Act, regarding prompt payment of claims; or

(vi) Failed to comply with the requirements of § 417.479(c) through (h) of this title for Medicare, and § 417.479(c) through (g) of this title for Medicaid, regarding certain prohibited incentive payments to physicians.

(2) The OIG may, in addition to or in lieu of other remedies available under law, impose a penalty of up to $25,000 for each determination by HCFA that a contracting organization with a contract under section 1876 of the Act:

(i) Employs or contracts with individuals or entities excluded from participation in Medicare, under sections 1128 or 1128A of the Act, for the provision of health care, utilization review, medical social work, or administrative services; or

(ii) Employs or contracts with any entity for the provision of such services (directly or indirectly) through an excluded individual or entity.

(3) The OIG may, in addition to or in lieu of other remedies available under law, impose a penalty of up to $100,000 for each determination that a contracting organization has:

(i) Misrepresented or falsified information furnished to the Secretary under section 1876 of the Act, or to the State under section 1903(m) of the Act; or

(ii) Acted to expel or to refuse to re-enroll a Medicare beneficiary or Medicaid recipient because of the individual's health status or requirements for health care services, or engaged in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by section 1876 or 1903(m) of the Act) with the contracting organization by enrollees whose medical condition or history indicates a need for substantial future medical services.

(4) In cases where enrollees are charged more than the allowable premium, the OIG will impose an additional penalty equal to double the amount of excess premium charged by the contracting organization. The excess premium amount will be deducted from the penalty and returned to the enrollee.

(5) The OIG will impose an additional $15,000 penalty for each individual not enrolled when it is determined that a contracting organization has committed a violation described in paragraph (e)(3)(ii) of this section.

(6) For purposes of paragraph (e) in this section, a violation is defined as each incident where a person has committed an act or failed to comply with a requirement set forth in §§ 417.495(a), 434.67(a), or 434.80(c) of this title, as determined by HCFA.

6. Section 1003.106 is amended by adding new paragraph (a)(4); redesignating paragraph (d) as paragraph (e) and republishing it; and adding a new paragraph (d) to read as follows:

§ 1003.106 Determinations regarding the amount of the penalty and assessment.

(a) * * *

(4) In determining the appropriate amount of any penalty or assessment under § 1003.103(e), the OIG will consider as appropriate:

(i) The nature and scope of the required medically necessary item or service not provided and the circumstances under which it was not provided;

(ii) The degree of culpability of the contracting organization;

(iii) The seriousness of the adverse effect that resulted or could have resulted from the failure to provide required medically necessary care;

(iv) The harm which resulted or could have resulted from the provision of care by a person that the contracting organization is expressly prohibited, under sections 1876(i)(6) or 1903(p)(2) of the Act, from contracting or employing;

(v) The harm which resulted or could have resulted from the contracting organization's expulsion or refusal to re-enroll a Medicare beneficiary or Medicaid recipient;

(vi) The nature of the misrepresentation or fallacious information furnished by the contracting organization to the Secretary, State, enrollee, or other entity under sections 1876 or 1903(m) of the Act;

(vii) The extent to which the failure to provide medically necessary services could be attributed to a prohibited inducement to reduce or limit services under a physician incentive plan and the harm to the enrollee which resulted or could have resulted from such failure. It would be considered an aggravating factor if the contracting organization knowingly or routinely engaged in any prohibited practice which acted as an inducement to reduce or limit medically necessary services provided with respect to a specific enrollee in the organization;

(viii) The history of prior offenses by the contracting organization, or principals of the contracting organization, including whether at any time prior to determination of the current violation or violations the contracting organization or any of its principals was convicted of a criminal charge, or was held liable for civil or administrative sanctions in connection with a program covered by this part or any other public or private program of payment for medical services; and

(ix) Such other matters as justice may require.

* * * * *

(d) In considering the factors listed in paragraph (e)(4) of this section, for violations subject to a determination under § 1003.103(e), the following circumstances are to be considered, as appropriate, in determining the amount of any penalty:

(1) *Nature and circumstances of the incident.* It would be considered a mitigating circumstance if, where more than one violation exists, the appropriate items or services not provided were:

(i) Few in number, or

(ii) Of the same type and occurred within a short period of time.

It would be considered an aggravating circumstance if such items or services were of several types and occurred over a lengthy period of time, or if there were many such items or services (or the nature and circumstances indicate a pattern of such items or services not being provided).

(2) *Degree of culpability.* It would be considered a mitigating circumstance if the violation was the result of an unintentional, unrecognized error, and corrective action was taken promptly after discovery of the error.

(3) *Failure to provide required care.* It would be considered an aggravating circumstance if the failure to provide required care was attributable to an individual or entity that the contracting organization is expressly prohibited by law from contracting or employing.

(4) *Use of excluded individuals.* It would be considered an aggravating factor if the contracting organization knowingly or routinely engages in the prohibited practice of contracting or employing, either directly or indirectly, individuals or entities excluded from the Medicare program under sections 1128 or 1128A of the Act.

(5) *Routine practices.* It would be considered an aggravating factor if the contracting organization knowingly or routinely engages in any discriminatory or other prohibited practice which has the effect of denying or discouraging enrollment by individuals whose medical condition or history indicates a need for substantial future medical services.

(6) *Prior offenses.* It would be considered an aggravating circumstance if at any time prior to determination of the current violation or violations, the

contracting organization or any of its principals was convicted on criminal charges or held liable for civil or administrative sanctions in connection with a program covered by this part or any other public or private program of payment for medical services. The lack of prior liability for criminal, civil, or administrative sanctions by the contracting organization, or the principals of the contracting organization, would not necessarily be considered a mitigating circumstance in determining civil monetary penalty amounts.

(e) (1) The standards set forth in this section are binding, except to the extent that their application would result in imposition of an amount that would exceed limits imposed by the United States Constitution.

(2) The amount imposed will not be less than the approximate amount required to fully compensate the United States, or any State, for its damages and costs, tangible and intangible, including but not limited to the costs attributable to the investigation, prosecution, and administrative review of the case.

(3) Nothing in this section will limit the authority of the Department to settle any issue or case as provided by § 1003.126, or to compromise any penalty and assessment as provided by § 1003.128.

(Catalog of Federal Domestic Assistance Program No. 93.773—Medicare—Hospital Insurance Program; No. 93.774—Medicare—Supplementary Medical Insurance Program; No. 93.778—Medical Assistance Program.)

Dated: September 25, 1992.

William Toby,

Acting Deputy Administrator, Health Care Financing Administration.

Dated: September 30, 1992.

Brian B. Mitchell,

Principal Deputy Inspector General, Department of Health and Human Services.

Approved: October 28, 1992.

Louis W. Sullivan,

Secretary.

[FR Doc. 92-29769 Filed 12-11-92; 8:45 am]

BILLING CODE 4120-01-M

The CHAIRMAN. I appreciate as always the great job that HCFA does, making Medicare the finest insurance system in the world. But my suggestion that it ought to be expanded to some other folks falls often on deaf ears.

But you could tell, can't you, Mr. Willis? If we had a whole team down there like Mr. Broglie, there is nobody that could touch us, right?

Mr. WILLIS. That is right.

The CHAIRMAN. All right.

Mr. WILLIS. Mr. Chairman?

The CHAIRMAN. Yes, sir?

Mr. WILLIS. If I may, since I am here there is just one point I would like to make, and that is the whole notion of health alliances being defined within State boundaries or, in our case, within the District of Columbia. As I view the health insurance market, it is a major metropolitan market.

As a regulator, if that thought is carried through in Federal legislation, that is going to create one heck of a problem here in river city. Companies market their products looking at the region and not just looking at the District. The issue that you have raised——

The CHAIRMAN. Well, you would be able to rate your own, they say, although they go back and forth. On the one hand, they say every State can write its own alliance regulations, but then they give us the list—they are beginning to give us the list of things that they will want the State to put in those, and it sounds very much to me like HCFA's regulations for Medicare are going to look minor compared to what they are going to have to write to run these alliances for which we have no point of reference. You haven't ever seen an alliance.

Mr. WILLIS. My concern is that if you have three State laws being applied to one alliance that is involved in an interstate operation——

The CHAIRMAN. No. As I understand it now, although that is a question we keep raising, each State has its own alliance.

Mr. WILLIS. I agree that is the way it looks today. I am just saying as a practical matter I am not sure that is the right solution for an area like Washington.

The CHAIRMAN. Practical matters don't phase Ira Magaziner one bit. [Laughter.]

Mr. WILLIS. It is on this side of the aisle at this point.

The CHAIRMAN. He hasn't seen a practical problem that he can't screw up in his career. He is a proponent of cold fusion. I would tell you to study those things, those suggestions out of the University of Utah. It will give you an idea how we get something for nothing. Mr. Broglie is going to have to write the regulation to see that it works.

So there will be something in this for all of us. For you two I suspect it will be regulations that you have yet to dream of, and let's hope that out of all of it in a spirit of happy cooperation the beneficiaries will get good medical care. How is that?

Mr. WILLIS. Okay. Thank you.

Mr. BROGLIE. Thanks, Mr. Chairman.

The CHAIRMAN. Adjourned.

[Whereupon, at 2 p.m., the committee was recessed. to reconvene subject to the call of the Chair.]

[The following additional material was subsequently received for the record.]

APPENDIX

GAO United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-254873

September 13, 1993

The Honorable Fortney H. (Pete) Stark
Chairman, Committee on District of Columbia
House of Representatives

Dear Mr. Chairman:

You asked us to supply information on three topics related to Medicare HMOs. These were the

-- status of open recommendations from past GAO reports related to Medicare HMOs,

-- implementation status of Section 4204 of OBRA '90 (P.L. 101-508) and

-- current position of marketing problems in Humana Medical Plan of South Florida

OPEN RECOMMENDATIONS

Relevant open recommendations are listed by report titles, which are underlined.

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, July 17, 1988)

Recommendation to the House Committee on Ways and Means, Subcommittee on Health: The Subcommittee should consider developing legislation to give the Health Care Financing Administration (HCFA) discretion to suspend Medicare enrollments in HMOs that fail to respond to notices of noncompliance in a timely manner, have recurring compliance problems, or are encountering financial difficulties, or failing to meet financial solvency requirements and not showing substantial progress in improving from one reporting period to the next.

This recommendation was reiterated as a conclusion in a subsequent report (GAO/HRD-92-11, see below).

Status: The Department of Health and Human Services (HHS) has submitted to the Congress a legislative proposal that

would meet the intent of the recommendation. The Congress has not yet acted as of this date.

Recommendation: The Secretary of HHS should direct the Administrator, HCFA, to issue regulations specifying the purpose of retroactive disenrollments and the circumstances, criteria, and procedures that must be met in authorizing such actions.

Status: HHS has revised its HMO manual, effective July 1992, to address the issues in this recommendation. HHS expects to issue relevant regulations in late 1993.

Medicare: PRO Review Does not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, March 31, 1991)

Recommendation: Although risk HMOs are required to cooperate with Peer Review Organizations (PROs), Congress should amend the Social Security Act to give HCFA explicit authority to impose such remedies as suspending enrollment or payments or imposing civil monetary penalties to help insure that risk HMOs comply in collecting and submitting the inpatient information needed by PROs to carry our their review responsibilities.

Status: HHS has submitted a legislative proposal that addresses the issues in this recommendation. The Congress has not acted as of this date.

Recommendation: The Secretary of HHS should direct the Administrator, HCFA, to provide leadership in encouraging participating risk HMOs to begin collecting centralized data on ambulatory care provided to Medicare enrollees.

Status: HHS does not intend to act on this recommendation because it considers centralization of records to be problematic.

Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991)

Recommendation: The Secretary of HHS should direct the Administrator, HCFA, to establish policies that specify the circumstances and timing regarding when it will impose sanctions on HMOs with Medicare risk contracts that are violating Medicare requirements.

The HCFA Office of Prepaid Health Care Operations and Oversight has issued written policies setting forth the process for initiating intermediate sanctions. However, these policies do not clearly specify the circumstances under which the sanctions will be imposed. In addition, the implementing regulations for intermediate sanctions have not yet been issued in final form and are thus not yet in force. (The proposed rule was issued July 22, 1991. According to an official of the HHS Inspector General's office, this regulation is presently with the HCFA Administrator's office for clearance.)

IMPLEMENTATION STATUS OF SECTION 4204 OF OBRA '90

Section 4204 of OBRA '90 (PL 101-508) placed certain restrictions on physician incentive plans within HMOs with Medicare risk contracts. These restrictions were intended to prevent the HMOs from placing subcontracting physicians or physician groups under excessive risk for costly services not provided directly by the physician for patients under the physicians' care. However, certain crucial definitions, such as what constitutes substantial financial risk and adequate stop-loss protections, were left to the Secretary. Thus, this provision cannot very well be enforced absent effective regulations.

A proposed regulation was published for public comment in the Federal Register of December 14, 1992. The rule has not yet been issued in final form and is currently under revision in HCFA.

When we analyzed the proposed rule, the thresholds for "substantial financial risk" (25 percent of total payments from the HMO to the physician or physician group at risk for plans that distribute incentive payments no more than annually, 15 percent for those that distributed payments more than annually) seemed rather high. Below these thresholds, the law's requirements that the HMOs must have a form of stop-loss protection to avoid placing excessive risk on physician subcontractors and must conduct periodic patient satisfaction surveys would not apply.

STATUS OF MARKETING PROBLEMS IN HUMANA MEDICAL PLAN

In our 1991 report (GAO/HRD-91-11), we reported HCFA's finding of serious marketing abuses in Humana Medical Plan in South Florida. These abuses resulted in enrollment of Medicare beneficiaries who did not understand the requirement that they obtain care only from plan providers.

B-254873

As a result, they sometimes incurred substantial medical bills that neither Medicare nor Humana would pay. The problems were so serious that in January 1990, HCFA began a formal investigation of Humana Medical Plan marketing practices. Officials in HCFA's Atlanta Regional Office believed that these marketing problems were in part caused by Humana's paying its marketing agents purely on a commission basis. (Humana did not use this payment method in all its Medicare markets.)

According to a HCFA official, Humana Medical Plan is still paying its marketing agents on a commission basis, although it has attempted to attract a better class of agent by giving these agents employee benefits. Further, the official said that the number of marketing complaints for Humana Medical Plan, relative to its size, did not exceed the average for other HMOs in the region and the nation.

We hope that this information helps you. If you have any questions, please do not hesitate to call Edwin Stropko, Peter Schmidt, or me at 512-7123.

Sincerely yours,

Sarah F. Jaggar

Sarah F. Jaggar
Director, Health Financing and
Policy Issues

JUDGMENT CALLS

ROBERT J. SAMUELSON

The Health-Care Crisis Hits Home

THE HEALTH-CARE CRISIS HIT HOME THE OTHER DAY. We received a packet in the mail from our local health-maintenance organization urging us to approve its takeover by Humana, a national health-care company. A "no" vote, we were warned, might jeopardize "the security of your health care coverage and your doctor relationship." That was put in **bold type**, just in case we missed the point. Agree or face the consequences. Pow, right in the kisser.

The gritty reality about health care is that, while everyone waits for President Clinton's mega-reform, the system is changing beneath us. This was my wake-up call. You may already have gotten yours, but if not, it's coming two weeks from now or two years from now. We're all going to struggle with uncertainties and changes that are, at best, inconvenient and, at worst, terrifying. Will we have to change doctors? Could our insurance coverage lapse? Will our out-of-pocket costs explode?

THE SYSTEM IS CHANGING AS WE WAIT FOR CLINTON'S REFORM PLAN

What's driving all the changes is soaring costs. To curb health spending, companies are cajoling or coercing workers into new insurance arrangements. The consulting firm KPMG Peat Marwick reports that about 38 percent of insured workers must now join some type of "managed care," such as HMOs. In 1988, this was 11 percent. Recently, Empire Blue Cross and Blue Shield—which insures 7.6 million people in New York—said it might require 120,000 of its riskiest patients to join HMOs or other managed-care groups. That worried the state's insurance commissioner. "Often they [the patients] feel they owe their lives to particular doctors," he told The New York Times, "and won't be able to survive in a managed-care environment."

The personal imperative to keep control of our own health care collides with the collective imperative to stop rising health costs from impoverishing us. Worse, it's hard to discuss these issues calmly and intelligently, because every confident generalization made in a policy debate somehow seems to run afoul of someone's personal experience or, at a minimum, requires an extensive footnote to reflect the diversity of what actually happens in doctors' offices, clinics and hospitals.

Consider my family's experience with HMOs. They are promoted as a way to control costs. Because HMOs are paid a flat annual fee per patient, they have no reason (the theory goes) to overuse tests or surgery to increase income. On the other hand, HMO critics raise two fears: first, people won't be able to pick their doctors and will get lost in giant bureaucracies; and second, HMOs ultimately control costs by skimping on care. At Group Health Association (GHA) in Washington, D.C., we haven't found either the good or bad stereotype to be true.

We like our doctors and, among GHA's staff, had a choice. Because my wife once worked at GHA, she had clear preferences. As for skimping, we have seen little evidence of it. Our youngest son, John (now 3½), had a bizarre experience when he was a few months old. He suddenly stopped breathing and lost color for about 30 seconds—and then spontaneously recovered.

At GHA, John was examined by the attending pediatrician (not our own). After questioning my wife, he concluded that the incident was a freak that probably wouldn't recur. At that point, I expected to be sent home. No. A lung specialist was summoned. Another exam. More questions. Same diagnosis. Now, I thought, we will be sent home. No. We were dispatched to a local hospital, where John was hooked up to monitors for overnight observation.

By contrast, GHA's economics are ugly. Its costs are high. Its computer systems are old. Legally, GHA is a nonprofit consumer cooperative (which is why members must approve the takeover), and there's a long history of bitter conflict between the doctors and the board of trustees. The doctors are unionized and, by contract, have an official workweek of—gulp!—only 35 hours.

Potentially, GHA is in a death spiral. Its patients are more middle-aged and costlier than average. "At 45, your body begins to fall apart, and you use more health services," says Robert Plotenhauer, GHA's chief executive. True enough. Nationally, average health costs for people 45-64 are almost twice as high as those for people 18-44. (Those over 65 are covered by Medicare.) High costs and premiums—family coverage now exceeds $5,000 a year—are driving away younger members and companies that want to cut health costs. Since early 1992, GHA has lost 21,000 members, nearly 15 percent of the total. It's barely covering costs.

My wife and I voted for the Humana takeover. Perhaps GHA could (as critics of the proposal argue) turn itself around, but that's not a gamble we like. Humana promises a new profit-sharing agreement with doctors that would raise their productivity. Likewise, Humana has modern computer systems. Finally, it has a strong practical reason to do well. Humana aims to be a national HMO leader. It won't want to make a mess in Washington, in front of Congress and the White House.

Our small family drama captures the larger problems of health care. We must change our system, but we're all afraid of change. It's disruptive and uncertain. Can I be sure that a more productive GHA won't become less personal? Nope. The uncertainty is inevitable, because almost anything that anyone says about our health-care system will be untrue for someone. My generalizations about GHA don't apply to all HMOs, for example. Some may be oppressively bureaucratic. Others might be highly efficient, even though possible cost savings are probably exaggerated. (The Congressional Budget Office recently estimated the potential savings at 10 percent.)

Health-care politics becomes a baffling mixture of personal anxieties and abstract policies. This is not good news. Once President Clinton proposes his reform, we will all wonder: what's in it for me? If it and the alternatives seem too threatening, there may be no consensus to do anything. The status quo may seem more comfortable and win by default. But this, too, would be a mirage. In health care the status quo is dying. Either we will orchestrate change or change will orchestrate itself.

JERRY SOLON, PhD
Health Services Research

13104 Matey Road
Wheaton MD 20906
301/942-9296

July 17, 1993

PERSONAL MESSAGE to: MY FELLOW MEMBERS,
GHA ROCKVILLE CENTER

I take this personal way of expressing my personal and professional view of the member referendum now under way. I do this to convey my sense of the urgency of our adopting the proposed sale of GHA to the Humana health-care organization.

Although I regret our putting behind us our cooperative framework--cooperative promoter that I've always been and actively continue to be--most important is that we assure GHA's survival as our health care provider. This, Humana enables us to do, and to do best, of all the other proposals that our Board has been soliciting and exploring this past year. Humana in fact has a track record of bringing other troubled HMOs to successful continuation!

Those of us who also care about retaining a healthy, constructive element of consumer involvement have been thoroughly assured by Humana's leaders that this will indeed be desirable. We're confident that a fitting arrangement will be jointly developed that will produce a win-win outcome for all.

So please make it possible for Group Health to continue to serve us, under Humana's sponsorship, by promptly sending your ballot in with a YES vote.

Jerry Solon

If you wonder where do I come off to offer this judgment to you, let me state my credentials for being so brash:

- 50+-yearlong actively-participating member of GHA, including decades of MAC membership, Board terms, numerous committees/councils/task forces, and active volunteer service at Rockville Center.
- Originator of local Member Advisory Councils in GHA.
- Founder & Chair Emeritus, Rockville Center's MAC.
- Newly elected Chair of GHA's central MAC.
- And alongside this GHA participation, a long professional career within the health field.

Hotel & Restaurant Employees
Local 25, AFL-CIO

July 30, 1993

Dear Local 25 Member,

I am writing to you with some important information about your Union medical insurance - Group Health Association.

You have probably heard that Humana Inc. has offered to purchase Group Health Association. I have reviewed the Humana purchase plan and I believe that it is good for GHA. It is also good for you and all Local 25 members. Humana will bring long term strength to GHA and they have promised to continue the coverage that we have under our Union contract.

As a member of GHA your have *a right to vote* on the Humana purchase.

You should have recently received a ballot. *If you have not voted yet, I urge you to vote YES on this ballot.* By voting *YES* you will be supporting the good benefits you receive through Group Health Association. Your vote is important. *Please mark your ballot and mail it back right away.*

If you have not received or have misplaced your ballot or if you have any questions, please call the GHA Member Hotline at 202-244-8683.

Sincerely,

Ron Richardson
Executive Secretary-Treasurer

RECEIVED
AUG 02 1993
MARKETING DEPT.

1003 K STREET, N.W., 7TH FLOOR, WASHINGTON, D.C. 20001 — (202) 737-2225

Hotel & Restaurant Employees
Local 25, AFL-CIO

30 de Julio, del 1993

Querido Miembro de Local 25,

Les escribo para darles información importante sobre su Seguro Medico suministrado por la Union - Group Health Association.

Ustedes quizá han oido que Humana Inc. ha ofrecido comprar Group Health Association. Yo he revisado el plan y creo que es bueno para GHA. Tambien es bueno para usted y todos los miembros del Local 25. Humana con su oferta trae fuerza para el futuro, y promete mantener los beneficios que tenemos en nuestro contrato de union.

Como miembro de GHA usted tiene el derecho de votar por este plan.

Deben de haber recivido un voto. Si no han votado, les pido que voten SI. En votar SI usted mantendra los buenos beneficios que reciven por Group Health Association. Su voto es importante. Por favor llene su voto y mandelo por el correo tan pronto le sea posible.

Si no ha recivido un voto o tiene preguntas sobre el plan, llame a la linea de servicios de Group Health Association #202-244-8683.

Sinceramente,

Ron Richardson
Executive Secretary-Treasurer

1003 K STREET, N.W., 7TH FLOOR, WASHINGTON, D.C. 20001 — (202) 737-2225

July 17, 1993

Dear GHA Fellow Members:

My message to you comes while wearing my membership hat. (The MAC officer hat is in the laundry.)

Seriously, when I spoke to you at the Annual Assembly last April, I tried to communicate to you that *CHANGE* is in the air in our geographic area, not just within GHA. Unfortunately, the outside world is influencing our need to change more than you and I would like. Thus we have few to no options. To remain the *same* is to be bankrupt and have no choice whatsoever in our future.

Fortunately, we do have a choice, and, I might add, a most impressive one in Humana. Yesterday noon I was one of those fortunate enough to meet David Jones, Humana's Chairman of the Board and Chief Executive Officer, and several other representatives of the company. Among the topics explored together were:

- Our strong desire for continued consumer involvement in committees and advisory boards.
- Continuous membership for all of us without excessive rate increases.

That entire session was devoted to our questions and their answers. There was no planned formal, slick presentation. I came away reminded the company name "Humana" includes the word "human." Mr. Jones expressed that he had a clearer picture of our commitment to the members and member involvement as a result of the questions, and I had the feeling he would use a humane and sensitive approach as both organizations work together to forge a successful alliance -- successful for GHA and Humana.

Shall we paint Humana into the picture I left unfinished in April's Annual Assembly?

Your fellow member,

Lorrie Van Akkeren

Lorrie Van Akkeren

FORMER TRUSTEES URGE A YES VOTE FOR
GHA/ HUMANA

The persons undersigned are all former members of the Board of Trustees of Group Health Association, and as such are aware of the financial condition of Group Health Association and of the competitive forces at work in the Washington metropolitan area.

After careful evaluation of the choices presented to Group Health at this time in its history, we urge that Group Health members support the current Trustees' recommendation that Group Health be sold to Humana.

We believe this sale is in the best interests of the members of Group Health and of its staff.

- Humana has agreed to provide continuity of members' health care coverage. No current members or groups will be dropped unless they fail to pay their premiums; employees of small groups would be able to convert to individual coverage if their organizations went out of business.

- The Humana sale will allow Group Health members to maintain their relationships with current Group Health physicians. Humana will use the existing Group Health physicians and other staff as the core of their health plan.

- Humana has committed to provide for continued consumer involvement . David Jones, the Chairman and CEO of Humana, has indicated that Group Health/Humana members could establish a member advisory board (elected by the members if they are so inclined) to provide input to Humana/ GHA and to him and his staff.

- Humana, which has extensive resources to draw on, can provide the capital that Group Health Association vitally needs to improve services to members, including improved and new centers and a broader network of providers.

PLEASE VOTE in this very important referendum on Group Health's future!

Virginia P. Brockington

Joan Hildwassen

Ann C. Wilson

Daniel J. Sullivan

Percy Dobson

SEP-14-93 TUE 9:06 CONGRESSMAN STARK ++ P.01
03/13/93 15:18 GHA EXEC OFFICE 002

GROUP HEALTH ASSOCIATION of Washington D.C.

MEMBER ADVISORY COUNCIL

The Honorable Fortney H. Stark
Chairman
Committee on District of Columbia
House of Representatives
The Capitol
Washington, D.C. 20215

September 10, 1993

Dear Congressman Stark:

As Chairman of GHA's Member Advisory Council, I'm interested to learn that you are having a Committee Hearing next week to inquire into the proposed sale of GHA to Humana, Inc.

Our Member Advisory Council is of course deeply involved in this matter in behalf of its constituency, the GHA members. And in fulfillment of my responsibility to the Member Advisory Council and the GHA membership at large, I will necessarily attend the Hearing, on Tuesday next.

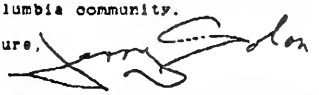
I gather that the "Member Rights Committee" has been invited to testify at the Hearing. It therefore behooves me to advise your Committee, lest it not be otherwise aware, that the ad hoc, self-organized, Member Rights Committee is not to be confused with our GHA Bylaws-mandated Member Advisory Council. It is the latter (commonly referred to as the "MAC") that officially represents the overall membership, in its mandated advisory role to the Board of Trustees. It is constituted by official delegates from the various Health Centers' local Member Advisory Councils.

Since we are not scheduled to testify at the Hearing, let me take this opportunity to declare the Member Advisory Council's support of the proposed rapprochement with the Humana organization. We accept and honor the membership's 91-percent approval of the sale. We especially seek to assure, thereby, that our many elderly, all-too-vulnerable members not be at risk of irrevocably losing health care coverage, should GHA not survive the overwhelming competition now roiling this market.

The Member Advisory Council, rather than unrealistically tilt at the crushing windmill, has responsibly engaged in assuring that provisions being arranged with the Humana organization will be advantageous to our GHA members. Thus, we have just completed formulating a plan for having a Consumer Advisory Council in our merging into Humana. And we have already been assured by Humana of its embracing such a consumer-representative entity in the forthcoming GHA-Humana arrangement.

I trust that you will recognize our official member-representative status in GHA, and our responsible member-protective input to the evolving arrangements with Humana. We are also participating in planning for a Group Health Foundation that will contribute health-related activities for the good and welfare of the District of Columbia community.

Sincerely yours,



Chair: Jerry Solon *Vice-Chairs:* Al Raisen, Lorrie Van Akkeren
Secretary: Howard Rohr

JS mail at GHA-RV Center, 6111 Exec. Blvd., Rockville MD 20852 ♦ 301/231-0400
or--(Home): 13104 Matey Road, Wheaton MD 20906 ♦ 301/942-8296

COMMITTEE ON THE DISTRICT OF COLUMBIA
U.S. HOUSE OF REPRESENTATIVES
PETE STARK, CHAIRMAN

NEWS RELEASE

For Immediate Release: September 3, 1993 **Contact: Broderick Johnson**

**THE HONORABLE PETE STARK (D., CA.), CHAIRMAN,
COMMITTEE ON THE DISTRICT OF COLUMBIA,
ANNOUNCES HEARING ON
PROPOSED SALE OF GROUP HEALTH ASSOCIATION TO HUMANA**

Washington, D.C. - - The Honorable Pete Stark (D., California), Chairman of the Committee on the District of Columbia, today announced that the Committee will hold a hearing on the proposed sale of Group Health Association, Inc. (GHA) to Humana, Inc. The hearing is scheduled for Tuesday, September 14, 1993, at 10:00 a.m., in Room 1310A of the Longworth House Office Building.

In announcing the hearing, Chairman Stark said "With over 132,000 GHA members in the Metropolitan Washington area, the proposed sale could have substantial affect on health care access and affordability in this region. A public hearing on the nature of the sale will bring to light potential risks and benefits of transactions of this type which are occurring more frequently across the country. "

Some of the issues the hearing will examine include:

- The trends in the health insurance industry to the formation of larger, for-profit health maintenance organizations.
- The experience with health maintenance organizations in delivering accessible and affordable health care to traditionally underserved populations.
- The governmental reviews necessary for approval of the sale of a not-for-profit health care corporation to a for-profit entity, and the extent of regulatory oversight of the operations of health maintenance organizations.
- The affect of the proposed sale on access to services and quality of care for current GHA members, particularly those in underserved areas.

"Some would have it that after health reform is complete, we would all enroll in Humana-style 'super HMOs'," Congressman Stark said. "If this is the vision of health reform, we need to take a closer look."

Invited witnesses will include local regulators, representatives of federal agencies and consumer groups, and GHA members. Oral testimony will be heard from **invited witnesses only**. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

(MORE)

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DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six copies are required and must be submitted by the close of business, Friday, September 10, 1993 to Broderick Johnson, Staff Director, Committee on the District of Columbia. An additional supply of statements may be furnished for distribution to the media and public if provided to the Committee office, 1309 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record, or any written comments in response to a request for written comments must conform to guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organizations for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

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